State of Georgia Open Enrollment 2008

TERMS & CONDITIONS

The Flexible Benefits Program is offered by the Employee Benefit Plan Council, the Board of Community Health and participating departments and authorities. The Flexible Benefits Program is governed by the Internal Revenue Code, section 125, and rules issued by the Employee Benefit Plan Council and the Board of Community Health. The Flexible Benefits Program provides you with a method to have your employer purchase benefits with money that would have been paid to you. You do not receive the premium amounts and contributions for the pre-tax options you select as taxable income (and therefore do not pay taxes on that amount); you do receive the benefits as an employer paid benefit. The Option Statement is a binding salary agreement. Failure to comply with all contractual and administrative requirements will result in any excess salary reductions being retained by the Plan. The following statements apply to the benefit options listed on the Option Statement and on the Open Enrollment web site.

1) Your participation in the Flexible Benefits Program is voluntary. You are not required to choose any of the options. If you do not wish to participate in these benefits, mark 'no coverage' in each benefit category, sign and date the Option Statement, and return it to your personnel or payroll office. If you choose your benefits through web enrollment, click 'no coverage' in each benefit category and complete the confirmation process.
2) The coverage levels available to you and the premium amount for each coverage level may be calculated using your retirement salary, your age, your eligibility for disability retirement benefits, and FICA status. Any errors in your age, salary, eligibility for disability retirement benefits or FICA status should be reported to your personnel or payroll office immediately.
3) The calculation of tax savings does not take into consideration any other income reduction program such as Deferred Compensation or Tax Sheltered Annuities, or any changes you may make in coverages for the upcoming year.
4) By selecting coverages and indicating contributions to Spending Accounts, you are agreeing that your agency may reduce your taxable income by the amount necessary to purchase those coverages and make those contributions. Except in certain circumstances, the amount of income reduction may not be changed until the next enrollment period.
5) For dependent and/or spousal coverage, it is your responsibility to notify the Flexible Benefits Program if the person ceases to be eligible to participate in the Plan. There will be no refund of premiums, paid into the Plan, when a timely change is not made.
6) After this enrollment period you may become a participant or make changes in some coverages only under limited conditions in accordance with the rules of the IRS code, the Employee Benefit Plan Council, and the Board of Community Health. The Employee Benefit Plan Council and the Board of Community Health have the responsibility to interpret these rules and make the final decision as to whether you may enroll or change any coverage outside of the enrollment period. Your request for enrollment or a change outside of the enrollment period will only be considered if you submit the proper documentation within the timeframe allotted. To submit a request for enrollment or change to coverage under the State Health Benefit Plan, you must complete and submit a Membership or Discontinuation Form to your employer's Benefits Coordinator within 31 days. Your request for enrollment or a change in any other coverage under the Flexible Benefits Program must be submitted in writing to your employer's Benefits Coordinator within 30 days. Submission of a request for enrollment or a change, or the occurrence of one of the following events, does not guarantee that you will be able to enroll or change coverage outside the enrollment period. Please see your Benefits Coordinator if you have questions about when you may enroll or make changes outside the enrollment period. A list of events that might permit you to enroll or change one or more coverages under the Flexible Benefits Program:
   a) You gain or lose a spouse; or
   b) You gain (no time limit if due to judgment, decree or order) or lose an eligible dependent; or
   c) Your spouse or dependent becomes eligible for or loses coverage under another employer's plan, COBRA or a governmental plan; or
   d) An event causes your dependent to gain or lose eligibility for coverage under your employer's plan; or
   e) Your change of residence causes you or your spouse or dependents to gain or lose eligibility for coverage under your plan or another employer's plan; or
   f) The cost of your dependent care increases or decreases significantly and your dependent provider is not related to you, your spouse, or your dependent; or
   g) Your spouse's employer increases, decreases or ceases coverage, or conducts open enrollment; or
   h) You, your spouse or your dependent gain or lose eligibility for Medicare or Medicaid.
7) This salary agreement will be terminated if you change the agreement during the next enrollment period. If you do not change the agreement, your benefit choices will rollover in the next Plan year or default to a specified coverage.
8) If you are eligible to participate in the Plan, you terminate and are rehired during the same Plan Year, you must maintain the same options.
9) Options and coverage levels under the State Health Benefit Plan are set forth in the State Health Benefit Plan Document. Options and coverage under the Flexible Spending Accounts are set forth in the Flexible Benefit Plan Document. For all other benefits under the Flexible Benefits Program, the options and coverage levels offered conform to policies provided by the insurance company making the offer. By selecting an option and coverage level you agree to abide by the terms and conditions of that policy.
10) Contributions to Spending Accounts are voluntary. You should not participate in Spending Accounts until you thoroughly read the sections of the Enrollment Booklet related to Spending Accounts. By choosing to contribute money to one or more Spending Accounts you are agreeing to abide by the Rules of the Employee Benefit Plan Council related to Spending Accounts. In particular, you are agreeing to the following provisions:
    a) Money contributed for one type of Spending Account cannot be used to pay claims payable from another type of Spending Account.
    b) In general, the amount contributed for a Dependent Care Account cannot be greater than the earned salary of you or your spouse, whichever is less.
    c) If you are married filing separately, the amount contributed for a Dependent Care Account cannot be greater than $2,500.
    d) The validity of a claim against a Spending Account is determined in accordance with the Plan, Internal Revenue Code, and IRS regulations as interpreted by the Administrator subject to the appeal provisions of the Plan.
    e) Any money not reimbursable to you will be forfeited to the Flexible Benefits Program. Forfeited money will not be returned or paid to the employee but will be used to reduce the costs associated with providing this benefit.
    f) For the Spending Accounts, eligible expenses will be reimbursed in accordance with the Rules of the Employee Benefit Plan Council and the IRS code.
    g) For the Dependent Care Spending Account, you will not be reimbursed for more than the Plan has received from your department on your behalf.
    h) If you decide to activate and use the Spending Account debit card, you agree to abide by all requirements as indicated in the cardholder agreement received with the card.
11) By selecting the Specified Illness Benefit, you are agreeing to the following:
    a) I am asserting that to the best of my knowledge and belief, the answers to the questions on the application are true and complete. They are offered to American General Assurance Company as the basis for any insurance issued. It is understood and agreed that coverage will not become effective unless I am actively at work on the date of enrollment and the effective date of coverage.
    b) I understand and agree that no benefits are payable for loss starting or occurring within 12 months of the effective date of coverage which is caused by, contributed to by, due to or resulting from a Pre-existing condition, unless I have gone 12 months without medical care, treatment or supplies for the Pre-existing condition.
    c) I realize that any false statement or misrepresentation may result in loss of coverage under the certificate. I understand that no insurance will be in effect until approved by American General Assurance Company and the necessary premium is paid. Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
    d) I authorize my employer to deduct the appropriate amount from my earnings and to deduct and pay American General Assurance Company the premium required thereafter each month for my insurance.
12) Other terms and conditions:
    a) If you choose not to participate or choose not to continue coverages, your ability to enroll at a later date will be subject to contractual provisions, which may include medical proof of insurability or limited coverages.
    b) If you failed to enroll in options requiring medical underwriting when first eligible and you choose new or increased levels of coverage, you must complete the medical underwriting process and be approved.
    c) If you choose coverage under the Life Insurance options and the Accidental Death and Dismemberment options, the same Beneficiary Election Form will be used. If a beneficiary is not named, your Estate will be the beneficiary.
    d) If you select more than $50,000 under the Life Insurance option, you may choose to pay the premium with after-tax dollars to avoid imputed income; this will eliminate any tax savings on the life insurance premium.
13) In the event of an administrative error with respect to the Flexible Benefits Program, decisions will be made in accordance with the Internal Revenue Code, the Rules of the State Health Benefit Plan, and the Rules of the Employee Benefit Plan Council for the Flexible Benefits Program.

Please choose your Plan coverage carefully. Only eligible dependents, as defined by the Plan Administrator and in Program communications, can participate in the Flexible Benefits Program. Any attempt to file claims for a dependent who is not eligible for coverage is fraud. The Plan Administrator will require repayment of any ineligible claims. If the employee purchased family coverage but is only eligible for single coverage, the difference in the premiums paid into the Plan will not be refunded. Also, the difference between single coverage and family coverage premiums will be included as income on a W-2 and/or amended W-2 for inclusion on the employee's tax return. Additionally, the inclusion of ineligible dependents for coverage under the Flexible Benefits Program may result in termination from the Program and/or prosecution for fraud.

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Welcome to the State of Georgia Flexible Benefits Program

Are you planning or expecting the birth or adoption of a child? Getting married soon? Are you caring for an aging parent? Is it time to start thinking about supplementing your retirement? These are just some of life's changes that could affect the health care and financial needs of you and your family.

This 2008 ***You Decide!*** booklet gives you an opportunity to review and understand your benefits package. It summarizes benefits available to State employees and their eligible dependents, along with certain procedures to be followed to obtain these benefits.

There are some plan enhancements for the 2008 Plan Year, so review all information carefully. It is up to you to understand all the options available and make the choices that best suit your needs. Making the right decisions about your options can make a real difference toward building a rewarding future for you and your family.

WHAT'S NEW!

AGENCY CHANGES

- The Georgia Merit System's name has been changed to the State Personnel Administration. Our web site address has changed to www.spa.ga.gov.
- Email addresses for our staff have changed to the new format: john.doe@.ga.gov

ADMINISTRATIVE FEES

- Administrative fees for Flexible Benefit Options will change to 30 cents for each option you choose to enroll in, with the exception of Spending Accounts and the Health Savings Accounts.
- Spending Accounts administration fees will change for Plan Year 2008:
  - General Purpose/Limited Purpose Health Care Spending Accounts - $2.00
  - Dependent Care Spending Account - $1.00
  - Total, if employee has both - $3.00

MEDICAL UNDERWRITING

- During Open Enrollment, employees selecting coverage(s) that require medical underwriting will initially receive the Guaranteed level of coverage. If the vendor approves the requested level of coverage, the premium and coverage will change, as of the first of the month following approval.

➢ **FOR THE 2008 OPEN ENROLLMENT PERIOD ONLY!**

- Current employees may select or increase Long-Term Care without medical underwriting.
- Current employees may select or increase Specified Illness coverage up to $10,000 without medical underwriting.
- Current employees may select or increase Spousal Specified Illness coverage for $5,000 without medical underwriting.

DEADLINE CHANGES

Event	Days to Complete
New Hire Enrollment	30
Qualifying Change of Status Event – Increase/Enroll Coverage	30
Qualifying Change of Status Event – Decrease/Cease Coverage	30

Flexible Benefits Program Calendar

	What to Expect… When
Oct. 1, 2007	All pay-related benefits (employee life insurance, AD&D, and disability) are based on your Benefit Salary and/or Benefit Age on this date.
Oct. 10 - Nov. 9	Open Enrollment period. Mandatory electronic open enrollment.All necessary forms and instructions will be available to you on the Open Enrollment web site, www.gabenefits.org Confirmation statements prepared, completed, and distributed showing the amount that will be taken from your paycheck beginning in December. Check your Statement carefully to be sure your choices have been recorded correctly. Contact your personnel/payroll office immediately if you discover an error.
Nov. 9, 2007	Your deadline for completing web enrollment and all required forms (including medical underwriting forms).
Dec. 15, 2007	Your first payroll reductions of the new plan year for your health benefit plan premiums and one-half of your monthly spending account contributions. (Note: This date may be different for educational entities.)
Dec. 31, 2007	Your first payroll reductions of the new plan year for premiums for all other Flexible Benefit options and the remaining one-half of your monthly spending account contributions. (Note: This date may be different for educational entities.)
Jan. 1, 2008	Coverage effective date for FLEX… provided you are not absent from work on the first scheduled work day in January due to illness or disability; and have met all contractual and administrative requirements.
Feb. 1, 2008	Notify your personnel/payroll office if you have not received your SHBP ID card or Notice of HMO Membership Action form by this date.
March 15, 2008	Last day to incur eligible expenses for reimbursement from the 2007 General and Limited Purpose Spending Accounts.
May 31, 2008	Deadline for filing Spending Accounts claims incurred during the 2007 Plan Year – January 1 - December 31, 2007. Claims must be postmarked by this date.
Nov. 28, 2008	Last salary reductions for Flexible Benefit premiums for 2008.
Dec. 31, 2008	Last day of coverage for the 2008 plan year, and the last day to incur eligible expenses for reimbursement from the Dependent (Child) Care Spending accounts for the plan year.
May 31, 2009	Deadline for filing Spending Account claims for expenses incurred during the 2008 Plan Year – January 1 - December 31, 2008. Claims must be postmarked by this date.

Who's Eligible To Participate

In general, you are eligible to participate in the Flexible Benefits Program if:

- You are a full-time regular employee who works at least 30 hours a week and are expected to work for at least nine months. Employees who work in a sheltered workshop or work transition program, contingent employees, temporary employees, and student employees are not eligible.
- You are a public schoolteacher, working at least 17.5 hours, and employed in a professionally certified capacity, working half time or more and not considered a "temporary" or "emergency" employee.
- You are an employee of a local school system holding a non-certificated position. You must be eligible to participate in the Teacher's Retirement System (TRS) or its local equivalent, and you must work a minimum of 20 hours a week (or 60% of the time necessary to carry out the duties of the position, if that's more than 20 hours).
- You are an employee of a local school system working at least 15 hours (or 60% of the time necessary to carry out the duties of your position, if that's more than 15 hours) and you are eligible to participate in the Public School Employees' Retirement System (PSERS), as defined by Paragraph 20 of Section 47-4-2 of the Georgia Code.
- You are an employee of a county or regional library and work at least 17.5 hours per week.
- Others deemed eligible by Federal or Georgia law.

If you aren't sure whether you're eligible, contact your personnel/payroll office.

PLEASE NOTE:
Benefit Options Administrative Fees
Beginning with the December, 2007 reductions/ deductions for January 1, 2008 coverage, the 30¢ administrative fee will be added to each premium with the exception of Spending Accounts.

Spending Account participants are assessed the following fees:

- General Purpose/Limited Purpose Health Care Spending Accounts - $2.00
- Dependent Care Spending Accounts - $1.00
- Total, if employee has both - $3.00

The HSA is subject to a separate fee schedule.

Pre-Tax Premiums Help You Stretch Your Dollars
The Flexible Benefits Program allows you to save on taxes while you pay for your benefits. Pre-tax premiums reduce your taxable pay…and your taxes. That's because premiums for most of your insurance options, health benefit options, and spending account contributions are taken out of your paycheck before federal and state income taxes and Social Security (FICA) taxes are withheld.

This means your taxable pay is lower…and so are your taxes. It also means you have more in your paycheck - or more to spend on benefits than you would if you paid the same premiums with after-tax dollars.

The example on the next page shows the impact of the pre-tax advantage for an employee earning $25,000 a year with annual pre-tax premiums of $1,800.

Your Benefit Salary - which includes your base salary and salary supplements that are regular, non-temporary, and not more than the amount on which retirement contributions are calculated - is reflected on your Option Statement and remains constant for the entire Plan year. Benefit Salary is the pay used to calculate your pay-based coverage - employee life, AD&D, and disability.

A Few Words About Pre-Tax Premiums
Using pre-tax premiums will not affect other employee benefits that are based on pay, such as any State of Georgia retirement system, life insurance, disability, and pension benefits. Those benefits will be based on your full pay before pre-tax premiums are taken out.

- Pre-tax premiums are not available for short-term disability, spouse life and child life, legal, long-term care insurance or specified illness.

Points To Consider

Whether you're single with no children, single with children, married with no children, or married with children, consider these points if…

Your Spouse Has Benefit Coverage

- **Spending Accounts**
  If your spouse's plan offers spending accounts, you can each have a Health Care Spending Account at the maximum allowed. For Dependent (Child) Care Spending Accounts, however, IRS laws restrict your total family contributions to $5,000 per year. For the 2008 Plan Year (January - December 31) contributions will be limited to $4,992.

- **Health Savings Accounts**
  If your spouse's plan offers spending accounts and your spouse is enrolled in a Health Care Flexible Spending Account or another non-HDHP plan, you are deemed 'covered' by a non-qualified Health Plan, and are thus

	with after-tax premiums	with pre-tax premiums
Annual pay	$25,000	$25,000
Annual pre-tax premiums	0	1,800
Taxable pay	$25,000	$23,200
Income and FICA taxes	– 3,513	– 2,997
Annual after-tax premiums	– 1,800	– 0
Take-home pay	$19,687	$20,203

With pre-tax premiums, this employee saves $516 in taxes, and has $516 more to spend on other benefits… or to take home.

• Pre-tax premiums are available only for the state-wide benefits offered through the Flexible Benefits Program; they are not available for other agency-sponsored benefits. This example is based on a married employee filing a joint return and claiming four exemptions.

Age Today	Reduction in Social Security Benefits at Age 65
25	2.6%
35	2.3%
45	1.7%
55	0.8%

Based on pay of $25,000 and $2,500 in pre-tax premiums until age 65.

ineligible from participating in the Health Savings Account.

You Are A New Employee

- **Dental**
  There is a much shorter waiting period in the Regular and PPO options if you sign up immediately. Late enrollment penalties will apply to the Regular and PPO options if you do not enroll now, but elect to do so in the future. The Prepaid Option does not have waiting periods or late enrollment penalties.

- **Spending Accounts**
  If you are hired by the State after October 1, your paycheck reductions for the spending accounts will start the 15th of your first full calendar month of employment. Your total contributions to each account are prorated by the number of months you participate in these options up to the maximum monthly amount allowed for each account.

  Once you enroll, you may submit claims for services incurred on or after the first of the month after you have completed one full calendar month of employment. If, for example, you are hired July 8 and sign up for a spending account, reductions will start on August 15. You can begin submitting claims for services that you incur on or after September 1.

- **Health Savings Account**
  If you are hired by the State after January 1 and elect to participate in the State Health Benefit Plan (SHBP) High Deductible Health Plan, you are not eligible to enroll in the Health Savings Account until the first of the month coinciding with or after your effective date of the High Deductible Health Plan. To determine your maximum contribution amount, please refer to the Health Savings Account section of this booklet.

- **Long-Term Care**
  You have a one-time opportunity to sign up for long-term care insurance without providing medical underwriting.

- **Employee Life, Spouse Life and Child Life**
  You have a one-time opportunity to choose some employee, spouse and child life insurance coverage without providing medical underwriting. The chart on page 9 lists medical underwriting requirements.

- **Specified Illness**
  You have a one-time opportunity to sign up for the Specified Illness guaranteed levels ($5,000 and $10,000) without providing medical underwriting.

FOR THE PY 2008 OPEN ENROLLMENT PERIOD ONLY – Current employees may select Long-Term Care with no medical underwriting required.

FOR THE PY 2008 OPEN ENROLLMENT PERIOD ONLY – Current employees may select up to $10,000 of Specified Illness coverage with no medical underwriting required.

FOR THE PY 2008 OPEN ENROLLMENT PERIOD ONLY – Current employees may select up to $5,000 of Spousal Specified Illness coverage with no medical underwriting required.

- **Disability**
  - There is a one-time opportunity to sign up for long-term disability coverage without providing medical underwriting during your new hire eligibility period. If you did not sign up then, you will need to complete an Evidence of Insurability Form.
  - There is a one-time opportunity to sign up for short-term disability without being subject to a late entrant waiting period during your new hire eligibility period. If you did not sign up then, you will be subject to the Late Enrollment Penalty.

- **Other Coverage**
  There are no medical underwriting requirements at any time for legal insurance, AD&D, spending accounts, or vision benefits.

Be sure to consider your options carefully when you first enroll. If you decline or drop some of your State coverages and want to pick them up again another year, you may have to prove insurability through medical underwriting to be covered again, or have longer waiting periods to receive full benefits.

When Your Spouse Works For The State

- **Dental**
  Each of you may take single coverage and enroll in different options if you choose, but your children will not be covered. As an alternative, one of you may take family coverage and cover your spouse and children. If you both take family coverage, the most the plan will pay is 100% of the allowable expenses.

- **Spending Accounts**
  - o Health Care Spending Account (HCSA)- Each of you may have a Health Care Spending Account for the maximum allowed ($5,040).
  - o Dependent (Child) Care Spending Account (DCSA) – the family maximum allowed is $4,992.

- **Health Savings Account**
  If one of you has a Health Care Spending Account, the spouse cannot enroll in the Health Savings Account option. The spouse who has the High Deductible Health Plan coverage will be the individual entitled to opening the HSA account and have payroll deductions taken.

➢ *If you are married to a State employee covered by the Flexible Benefits Program, make sure you understand how your coverage works together. You may have some advantages.*

- **Long-Term Care**
  Each of you may enroll for the coverage you need.

- **Legal Services Insurance**
  Each of you may take single coverage; in this case, your children will not be covered and some benefits may overlap. Or, one of you may take family coverage, which will cover the other spouse and your children. Coordination of Benefit Rules may apply.

- **Employee Life and AD&D**
  Each of you may enroll for the coverage you need.

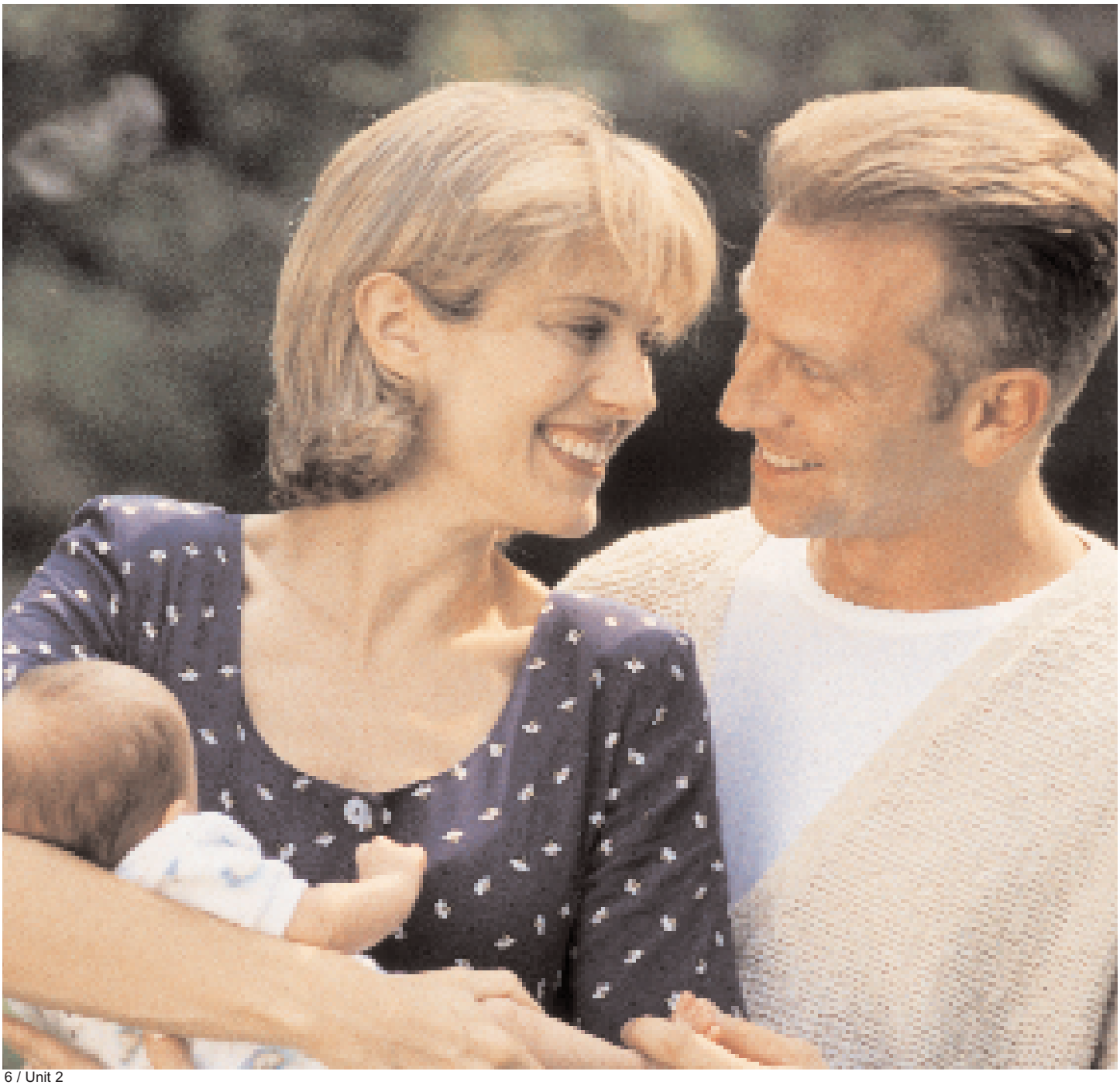
- **Spouse Life**
  Each of you may provide Spouse Life insurance for the other. Or, if you wish, one spouse may take coverage and the other spouse could choose “no coverage.”

- **Specified Illness**
  Each of you may enroll for the coverage you need.

- **Child Life**
  Each of you may provide Child Life insurance for your eligible children. Or, if you wish, one spouse may take coverage and the other spouse could choose “no coverage.”

- **Disability**
  Each of you may enroll for the coverage you need.

Signing Up For Coverage



Forms to Complete

Depending on the benefit choices made, you may be required to complete forms in addition to your Option Statement, such as:

- Minnesota Life Evidence of Insurability Form for approval of employee life, spouse life, and child life. If you make any of these benefit selections on the web, you must complete the medical underwriting form on the web.
- Health Savings Account Enrollment Form to be approved for the Health Savings Account. The form must be completed in full and provided to SHPS, Inc.
- AIG American General Evidence of Insurability Form to be approved for specified illness. If you select specified illness on the web, you must complete the medical underwriting form on the web.
- Unum Group Long-Term Care Insurance Application Evidence of Insurability Form to be approved for long-term care coverage. This medical underwriting form is not available on the web. When you have completed the form, return it to your personnel office.
- The Standard Company Evidence of Insurability Form to be approved for long-term disability. If you select long-term disability on the web, you must complete the medical underwriting form on the web.
- Enrollment forms for the Prepaid Dental option.

For dental insurance
If you enroll in the Prepaid Dental Option, you must complete a dentist Selection Form to pre-select a participating dentist prior to being able to use your dental insurance. Be sure to include dependent information on this form. Call CIGNA's Dental Member Services at 1-800-642-5810 or go online at www.cigna.com to obtain the Dental Selection Form.

Note: Health insurance forms are not applicable to the dental benefit.

For Employee, Spouse, and Child Life Insurance

In addition to your Option Statement or web enrollment, you may be required to complete the life medical underwriting process. If you are a current employee or new employee, the chart on page 9 will assist you in determining medical underwriting requirements.

- **Minnesota Life Evidence of Insurability Form**
  If you or your dependents are required to undergo the employee life, spouse life and child life medical underwriting process, you must complete the underwriting process on the web during open enrollment, or if you are hired after October 1, 2007, you must obtain the paper Minnesota Life Evidence of Insurability Form from your personnel/payroll office and submit within 30 days of your hire date. Based on the information you provide on the form, the insurance company may require additional medical information for clarification.

- **Amplified Blood Test**
  In addition to the Minnesota Life Evidence of Insurability Form, your employee and/or spouse life insurance selection may require the completion of an amplified blood test. After Minnesota Life receives your Evidence of Insurability Form, the paramedic company responsible for collecting a blood sample will contact you. The amplified blood test includes measurement of blood pressure, pulse, height, and weight. It may also include an EKG in certain circumstances. You will not be charged for this test. The amplified blood test is never required for child life insurance selections. If you have any questions about the amplified blood test process, please call Minnesota Life toll free at 1-800-660-2519.

  When you request new or additional coverage, and your medical history warrants, the insurance company may ask for additional information, including an amplified blood test, even if your new coverage is for less than $150,000. You must complete by the deadline or coverage may be denied.

- **Minnesota Life Insurance Beneficiary Election Form**
  The first time you enroll in employee life insurance coverage, remember to complete the Flexible Benefits Beneficiary Election Form to name your beneficiaries. If your address changes or you desire a beneficiary change, update your beneficiary information by completing another Flexible Benefits Beneficiary Election Form. Be sure to return the completed form to your Personnel Office. You are always the beneficiary of your spouse life and/or child life insurance option.

For Specified Illness Insurance

In addition to your Option Statement or web enrollment, you may be required to complete the medical underwriting process. If you are a current employee or new employee, the chart on page 8 will assist you in determining medical underwriting requirements.

- **AIG Evidence of Insurability Form**
  If you are required to undergo the specified illness medical underwriting process, you must complete the underwriting process on the web during Open Enrollment or if you are hired after October 1, 2007, you must obtain the paper AIG American General Evidence of Insurability Form from your personnel/payroll office and submit within 30 days.

- **AIG Beneficiary Form**
  The first time you enroll in Specified Illness, complete the AIG Beneficiary Form and mail it to the address on the form. If you wish to update your information, complete another form and mail it to AIG.

Long-Term Care Insurance

- FOR THE PY 2008 OPEN ENROLLMENT ONLY – current employees may select or increase LTC coverage with no medical underwriting required.
- Outside of the PY 2008 Open Enrollment period, if you are a current employee and wish to choose long-term care for the first time or have discontinued coverage and are re-enrolling or are currently in the plan and wish to increase your benefit level or add options, you must complete the Long-Term Care Application. Call Unum at 1-888-SOG-FLEX (1-888-764-3539) or contact your local personnel/payroll office for an application. The long-term care medical underwriting process cannot be completed on the web.
- If you are a new employee and select this coverage, you do not have to complete this form. Simply, select this coverage on your Option Statement.

For AD&D Insurance

If you have enrolled in life insurance coverage, the beneficiary you name for your life insurance benefits is also the beneficiary for your AD&D benefits. If you did not take life insurance coverage, you should complete a Flexible Benefits Program Beneficiary Election Form for your AD&D coverage. You can change beneficiaries any time by filing a new form with your department.

For Long-Term Disability Insurance

If you are a current employee choosing coverage for the first time, or discontinued coverage and/are re-enrolling, you must complete the disability medical underwriting process on the web during Open Enrollment or if you are hired after October 1, 2007, you must obtain the paper form from your personnel/ payroll office and submit timely.

- **The Standard Company Evidence of Insurability Form**
  The Long-Term Disability medical underwriting process includes the completion of the Evidence of Insurability Form. The form must be completed by the designated deadline. Based on the information you have provided, the insurance company may require additional medical information for clarification.
- If you are a new employee and select the long-term disability option, you do not have to complete the medical underwriting process.

After you've decided which benefits are best for you, it's time to sign up for them. Refer to the employee checklist on page 46 to assure you are covering all bases.

Additional Required Information

Additional information you may be required to furnish may include medical history questions, medical records from your physician, an amplified blood test, and/or a paramedical examination. There is no additional expense to you for the blood test or for medical records. To speed up the medical underwriting process, you may be contacted by telephone for additional information by The Standard or one of The Standard's representing companies. If you have any questions, please contact The Standard's Medical Underwriting staff toll-free at 1-888-641-7186.

Specified Illness Medical Underwriting

For Current and New Employees	
Enrolling in Level 1 & 2 ($5,000 & $10,000 coverage)	Current Employee – No Medical Underwriting required if selected during the 2008 Open Enrollment period. New Employee – No Medical Underwriting required.
Enrolling in Level 3,4,5, or 6 $20,000, $30,000, $40,000 or $50,000	Medical Underwriting required by the carrier
Enrolling in Spouse Coverage ($5,000)	Current Employee – No Medical Underwriting required if selected during the 2008 Open Enrollment period. New Employee – No Medical Underwriting required

Life Insurance Medical Underwriting

Current Employees

Enrolling for the first time, re-enrolling or increasing coverage

Employee Life	Life Medical Underwriting Requirements
Enrolling for the first time in any level. Discontinued coverage and re-enrolling.	Evidence of Insurability form required. Amplified Blood Test required for coverage over $150,000.
Currently Enrolled in Employee Life and increasing coverage.	Evidence of Insurability form required. Amplified Blood Test required for coverage over $150,000.
Spouse Life	**Life Medical Underwriting Requirements**
Enrolling for the first time in any level. Discontinued coverage and re-enrolling	Evidence of Insurability form required. Amplified Blood Test required for coverage over $150,000.
Child Life	**Life Medical Underwriting Requirements**
Enrolling for the first time in any level of coverage Discontinued coverage and re-enrolling	Evidence of Insurability form required.

New Employees

Enrolling for the first time

Employee Life	Life Medical Underwriting Requirements
Enrolling in One times pay (capped at $250,000)	NONE
Enrolling in Two, Three, Four, Five, Six or Seven times pay	Coverage over $100,000 Evidence of Insurability form required. Amplified Blood Test required for coverage over $150,000
Spouse Life	**Life Medical Underwriting Requirements**
Enrolling in coverage up to and including $30,000	NONE
Enrolling in coverage over $30,000	Evidence of Insurability form required. Amplified Blood Test required for coverage over $150,000
Child Life	**Life Medical Underwriting Requirements**
Enrolling for the first time in any level	NONE

When coverage begins
Coverage for new options selected during the Plan Year 2008 Open Enrollment will begin on January 1, 2008 as long as you have met all contractual and administrative requirements.

Your new premiums for your health benefit plan and spending account reductions begin December 14; other premiums begin December 31 (for semi-monthly pay periods). See specific plan descriptions for information about when your coverage begins.

If you are a new employee, complete your personalized paper Option Statement and other needed forms by your department's deadline, but no later than 30 days after your hire date. Your coverage will begin on the first day of the month after you have completed a full calendar month of continuous employment.

Confirming Your Choices
You will receive a Confirmation Statement. Check it to be sure your choices were correctly entered. The Confirmation Statement does not guarantee your coverage in some benefit coverages that require additional information. If you have not completed and submitted the additional forms/information required by your selected plan and have not been approved by the respective agencies, the choices shown on your Confirmation Statement for employee life, spouse life, child life insurance, and long-term disability insurance, specified illness, health savings account; long-term care, and State Health Benefit Plan PPO, Indemnity and HMO Options may not be valid.

Compare your paycheck statements with your Confirmation Statement. It is your responsibility to notify your personnel/payroll office immediately if there is an error. Any changes to your benefit selections must be in accordance with IRS §125 and Employee Benefit Plan Council rules and regulations and approved by plan administrators.

To Change Your Decisions at Annual Open Enrollment
Every Open Enrollment you can change your benefit decisions, based on which benefits are available and right for you. Remember, this is an annual agreement to allow the State to purchase some benefits for you through pre-tax premiums. You will not be able to change these benefit decisions until the next Open Enrollment unless you have a qualifying change in status as described in the Terms and Conditions.

To Change Your Decisions Outside Annual Open Enrollment
Qualifying Change in Status Event
In general, the Internal Revenue Service prohibits you from changing any coverage elections, or enrolling in or canceling any coverage under the Flexible Benefits Program outside of Open Enrollment. However, the rules of the Internal Revenue Service, the Board of Community Health and the Employee Benefit Plan Council do permit you to change coverage or enroll or cancel coverage in certain limited circumstances, if the change corresponds to a qualifying change in status event*.

**Note: Deductions for Health Savings Accounts (HSAs) fall outside of this requirement. Please contact your payroll department for details regarding changing your deduction mid-year.*

The Employee Benefit Plan Council and the Board of Community Health have the responsibility to interpret these rules and make the final decision as to whether you may enroll or change any coverage outside of the Open Enrollment period. Your request for enrollment or a change outside of the enrollment period will only be considered if you submit the proper documentation within the time frame allotted.

To submit a request for enrollment or changes to coverage under the State Health Benefit Plan, you must submit a completed Membership or Discontinuation Form to your employer's Benefits Coordinator within 31 days of a qualifying event (unless another time period is specified). Your request for enrollment or a change in any other coverage under the Flexible Benefits Program must be submitted on the Change in Status Event Form and given to your employer's Benefits Coordinator within 30 days of a qualifying event (unless another time period is specified). **There will be no refund of premiums paid into the Plan, when a timely change is not made.**

Submission of a request for enrollment or a change, or the occurrence of a qualifying event, does not guarantee that you will be able to change coverage outside the enrollment period. Please see your Benefits Coordinator if you have questions about when you may enroll or make changes outside the enrollment period. For a list of possible change in status events that might permit you to change one or more coverages under the Flexible Benefits Program, please refer to the Terms and Conditions in the front of this booklet. The changes outlined include dependent eligibility to participate in the Plan. When a dependent or a spouse ceases to be eligible to participate in the Plan, it is the responsibility of the employee to notify the Plan.

Generally, any changes will go into effect the first of the month following the date when the payroll deduction is changed to reflect your new choice. For some benefits, however, when you change coverage based on the acquisition of dependents, the coverage effective date for the new coverage may be retroactive to the date of the acquisition of the dependent in some circumstances, or may be the first of the month following the request to change coverage. Please see your Benefits Coordinator for the rules that apply to any specific coverage program.

If you have questions regarding a change in any of your coverages, first call your employer's Benefits Coordinator. If you need further information about eligibility for health coverage, call the State Health Benefit Plan at 404-656-6322 or 1-800-610-1863. For questions regarding other coverages, call the Flexible Benefits Program at 404-656-2730 or 1-888-968-0490.

What Happens If You Leave State Employment*
If you leave State employment, you can continue some of your Flexible Benefits Program choices. Please refer to the chart on page 12.

- You may be eligible to continue your medical, dental, vision coverage and/or Health Care Spending Account (general or limited) for you and eligible family members after your last day of employment.
- A conversion or portability feature may apply to your employee life, spouse life, and child life insurance, specified illness, long-term disability and/or AD&D coverage. It is the employee's responsibility to contact the vendors for the conversion or portability of coverage.
- You can be billed and pay directly for legal service insurance (Signature LegalCare) coverage for the rest of the plan year.
- You can continue long-term care. Unum will bill you directly.
- You can convert your Prepaid Dental option coverage to an individual policy and be billed directly by CIGNA Dental.
- Your Health Savings Account is owned by you, and will continue to exist even after leaving State employment. You will be contacted by the HSA custodian after your departure to request information with how you would like your account to be administered moving forward.

**It is the responsibility of each employee to contact the vendor directly, within the required timeframe, to continue coverage (see chart next page), unless you are retiring and wish to continue your dental insurance via your retirement annuity or continue your vision and/or Health Care Spending Account via COBRA. In these situations, you should contact the Flexible Benefits Program.*

If you leave active State employment and then return during the same plan year, your previous choices will remain in effect unless you report a qualifying change in status event.

When you go on leave without pay, contact your personnel/payroll office, the State Health Benefit Plan, and the Flexible Benefits Program. If you do not continue paying premiums for coverage, your benefits will be cancelled and you may be subject to penalties and wait periods, if allowed to re-enroll. You may be required to wait until the next Open Enrollment period to re-enroll. Be sure to review each Plan Description for each option and see your personnel/payroll office for more information.

Taking Coverage With You When You Leave

Benefits	Retiree Coverage Available Through Retirement Plan Benefit Deductions	Coverage Can Be Continued Through COBRA	Coverage Can Be Direct Billed By Carrier, ported or Converted To An Individual Policy	You Must Decide And Complete Forms Within
Dental Coverage • Regular & PPO • Prepaid Option	Yes Yes	Yes Yes	No Yes	COBRA — 60 days Convert 30 Days — Prepaid Option
Vision Coverage	No	Yes	No	60 days
Health Saving Account	No	No	Yes	Contact J. P. Morgan Chase & Co.
General/Limited Health Care Spending Account	No	Yes	No	60 days
Dependent (Child) Care Spending Account	No	No	No	—
Employee/Spouse/ Child Life Insurance	No	No	Yes	30 days
AD&D Insurance	No	No	Yes	30 days
Specified Illness	No	No	Yes	30 days
Disability Coverage Short-Term, Long-Term	No No	No No	No Yes	— 30 days
Legal Insurance	No	No	Yes (through the end of the Plan Year)	30 days
Long-Term Care	No	No	Yes	30 days

Dental

Dental Insurances

Under any of the dental options, single or family coverage is offered. Your cost depends on the option you choose and whether you select single or family coverage. You have a choice of up to three dental options. Due to availability, your best option may depend on where you live or work. For PPO and Prepaid, please check the availability of dentists carefully.

- Regular - For all employees.
- Preferred Provider Option – Specifically for employees who live or work in the metropolitan Atlanta, Augusta, Columbus, Macon, and Savannah areas.*
- Prepaid – Specifically for employees who live or work in the metropolitan Atlanta area.*

*If a PPO dentist or a Prepaid dentist is available in the area where you live or work, you may choose the applicable option. Under the PPO, you have the freedom to go to any dentist, but, there are benefits of using a PPO participating dentist. If your dentist leaves the Prepaid plan during the plan year, you must select another participating dentist.

*It is important that you consider your particular needs and be aware of the potential lack of convenience by choosing a dental option that does not have a dental provider in close proximity to where you live. In this case, you will not be able to change or drop your option.

Contact your personnel/payroll representative if you need assistance in choosing the PPO or Prepaid option. Consider the following:

- If you select the Dental PPO and choose to use a non-PPO dentist, you should expect to pay more out of pocket.
- If you select the Dental Prepaid option you must visit a dentist within the CIGNA Dental Care network to receive benefits. You will not receive benefits if you visit a dentist outside the network. You will have limited ability to change dental plans until the following Open Enrollment.

Your Dental Plan Choices (Please review carefully)

Regular Dental Option

- Benefits are determined using the 90th percentile rates for procedures.
- You may use any dentist you choose.
- You may choose a dentist in the available PPO network with benefits based on the maximum allowable charge (MAC). This may result in lower out of pocket costs.
- A non-network dentist is entitled to collect from you the difference between the amount of benefits payable by United Concordia and the dentist charge for that service.

Preferred Provider Option (PPO)

PPO Option

- Benefits are based on the MAC determined by United Concordia and accepted by the PPO dentist.
- Enrollment in the PPO is with the PPO Program, not with a particular dentist. PPO dentists can discontinue their arrangement with the Program at any time.
- If you require the services of a specialist, ask your dentist to refer you to a PPO specialist.
- If you use the services of a non-PPO dentist:

  The dentist is entitled to charge you the difference between the amount of benefits payable by United Concordia and the dentist's charge. This means you could pay more out-of-pocket expense for using a non-PPO dentist, because the payment will reflect the lower PPO scheduled fee.

Some Important Features Of The Regular and PPO Dental Options

There are some features to keep in mind when you use the dental options, Regular or PPO.

- The options of the State Health Benefit Plan (PPO, Indemnity, and HMO) provide limited, if any, coverage for dental treatment. See your SPD, UPDATERs and Health Plan Decision Guide for more information. For more detailed HMO information, contact the HMO directly.
- The PPO dentists have agreed to provide quality services at reduced rates. This means you save money if you use a PPO dentist. If you enroll in the dental PPO, receiving dental care from a non-PPOdentist can result in an increased out-of-pocket expense for you, as shown in the example on the following page.
- United Concordia uses the American Dental Association (ADA) procedure codes in effect at the time a claim is handled to determine benefits.

Pre-Determination of Benefits

Under the Regular and PPO Dental Options, for any service of more than $300, the service should be reviewed by United Concordia before receiving treatment. This is called a "pre-determination of benefits." *If treatment occurs without a predetermination of benefits and the service is denied, you may experience unexpected out-of-pocket costs.*

Some Exclusions For Regular and PPO Dental Options

Items and services that are not covered by the Regular and PPO Options are set forth in the Summary Plan Description for those options. Some examples include:

- charges for oral hygiene, plaque control programs, and

dietary instruction;
- the initial placement of full or partial dentures or bridges, if the prosthesis includes teeth that were missing before you were covered by the dental option.

Late Entrant Provisions for Regular and PPO
Late Entrant Limitations result in delayed benefits. This means you won't receive some benefits until you have participated in the dental plan for a specified period of time.

Late Entrant Limitations will apply to:
- current employees who are enrolling in either the Regular or PPO Options for the first time; or
- employees who fail to pay premiums when they are on an unpaid leave.
- current employees who choose not to continue coverage and re-enroll at a later date.

Late Entrant Limitations will <u>not</u> apply:
- if you enroll in the Prepaid Option as a new or current employee*
- when you transfer between the dental options (if not currently under Late Entrant);
- if you enroll in the PPO or Regular Option plan when you are first eligible as a new employee; or
- to employees who fail to pay premiums when they are on unpaid Family Medical Leave or Military Leave (if not currently under Late Entrant)

**New employees are not subject to the Late Entrant Limitations - as long as they enroll when first eligible. If you are a new employee and are interested in the Regular or PPO Options, sign up now to avoid these limitations in the future. Under the Regular and PPO Options, new employees have a six-month waiting period for Major and Orthodontic (dependents under age 19) services.*

Differences in the Regular and PPO Benefit Payments
There are differences in the benefits paid by the Regular and PPO Options for the same expense. There are advantages in using a PPO dentist, whether you choose the Regular or PPO dental option.
For example, with a $500 charge, an employee would pay:
- $100 if covered under the Regular Option and using a non-PPO dentist;
- $35 if covered under the Regular Option, but using a PPO dentist;
- $185 if covered under the PPO Option, but using a non-PPO dentist;
- $35 if covered under the PPO Option and using a PPO dentist;

So, whether you choose the Regular or PPO option, you save money by using a PPO dentist.

Prepaid Option

➢ ***If you plan to select or are continuing the Prepaid Dental Option, please read the Patient Charge Schedule carefully, since it has changed.***

- The Prepaid option through CIGNA Dental Care is an easy to use plan offering choice, quality, and savings with a focus on preventive care. Choose a general dentist from the CIGNA Dental network. Covered family members can each choose their own dentists, near home, work, or school.
- You will receive a Patient Charge Schedule listing all covered services and the corresponding patient charge for each service. For many services, there is no charge at all. Other plan features include: No deductibles to meet. No annual dollar maximums. No claim forms to file and no waiting periods for coverage.
- If you choose this option, you must select and use a CIGNA Dental Care Participating General Dentist to receive the benefits the option offers. Each family member you enroll may select a personal Participating General Dentist. If your dentist recommends specialty treatment, he/she will refer you to a participating CIGNA Dental Care Specialist. Whether seeing a general dentist or specialist, you will still only be responsible for the fees listed on your Patient Charge Schedule. Estimate and Plan for dental costs – CIGNA Dental introduces the Dental Treatment Cost Estimator which is a web-based tool that allows enrolled members to estimate and plan for their dental care costs.
- To find a participating CIGNA Dental Care network dentist call 1-800-642-5810 or log onto www.cigna.com.

➢ *Please read the Patient Charge Schedule carefully, as it has changed for the 2008 Plan Year. If a procedure is not listed on your Patient Charge Schedule, it is not covered. A full explanation of plan exclusions and limitations is included in your Patient Charge Schedule.*

Some Important Information About the Prepaid Option
- Once enrolled, you will receive a complete Patient Charge Schedule listing all covered services and associated fees along with your CIGNA Dental Care ID Card. Procedures not listed on the Patient Charge Schedule are not covered.
- You do not need your ID card to receive care. CIGNA Dental will send each dentist a monthly listing of all members who have enrolled with their office. You may request a Patient Charge Schedule by calling CIGNA

Dental Member Services at 1-800-642-5810 or online at www.cigna.com, then go to mycigna.com. This Patient Charge Schedule will provide a complete list of covered benefits and co-payments.

- If you choose the Prepaid Option, you must select and use a CIGNA Dental Care Participating Dentist. Otherwise, you will not be eligible for benefits.
- Each enrolled family member may select a different Participating General Dentist.
- To select a CIGNA Dental Care dentist for the first time, fill out and send in the Dentist Selection Form included in your enrollment materials. If you enroll in the CIGNA Dental Care plan but do not choose a dentist, one will be chosen for you based on your zip code. You have the option to change network dentists as often as you like by calling 1-800-642-5810, or by logging onto www.cigna.com. Your change will be effective the first day of the following month.

Did You Know ...

- Your dental benefits are not taxed, and most dental expenses that are not paid by dental coverage - such as deductibles and co-payments - can be submitted to your health care spending account, providing a tax savings of 26% - 45% on these expenses.
- Certain Restrictions, along with age and frequency limitations, apply to all dental options. For more information on the Regular and PPO Options, call United Concordia toll free at 1-866-215-2356. For more information on the Prepaid option, call CIGNA at 1-800-642-5810.

Dental Options Comparison Chart

	REGULAR	PPO	PREPAID
TYPE I – PREVENTIVE	100% of the 90th percentile***	100% MAC**	100% Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
TYPE II – BASIC	80% of the 90th percentile***	90% MAC**	100% Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
TYPE III – MAJOR	50% of the 90th percentile***	50% MAC**	60%* Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
ORTHODONTIA	50% of the 90th percentile*** for dependents under 19	50% MAC** for dependents under 19	50% for employee (and eligible dependents*) Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
ANNUAL DEDUCTIBLE	$50 per person; $150 for family (applies to Type II and Type III Major services only) each plan year		NONE
MAXIMUM BENEFITS	$1,000 per person each plan year; $1,500 lifetime benefit for Orthodontia		NO MAXIMUM
WAITING PERIOD FOR BENEFITS	New employees or newly enrolled dependents – after six months of continuous coverage for Type III Major services and Orthodontia		NO WAITING PERIOD
LATE ENTRANT LIMITATIONS FOR BENEFITS	Current employees enrolling for coverage for the first time after 12 months continuous coverage for Type II Basic services; after 24 months continuous coverage for Type III Major services and Orthodontia		NO LIMITATION

* Your share of the cost for these services will actually be a flat dollar co-payment. See Schedule of Benefits for details.

TYPE I – PREVENTIVE	TYPE II – BASIC	TYPE III MAJOR	ORTHODONTIA
• Oral exams • Prophylaxis • Space maintainers for dependents under 14 • X-rays	• Fillings • Root canals • Extractions • Scaling and root planing • Repairs to dentures, bridges, and crowns • Sealants, children under 16	• Crowns • Dentures • Bridgework • Surgical periodontal	• Cephalometric x-rays • Treatment study • Bands, appliances

**United Concordia reimburses all fee-for-service and PPO dentists according to the maximum allowable charge (MAC) schedules. The MAC is determined using charge data submitted to United Concordia from more than 100,000 participating providers.
United Concordia policies & procedures and exclusions limitations apply.
This chart is a representative listing of services covered under the program.

***You may use a PPO provider even if you enrolled in the Regular Dental Option.
This may result in lower out-of-pocket costs.

Vision

The Vision Plan, provided through Spectera, features:
- covered exams and materials;
- statewide access to a network of panel providers;
- no claims to file for "in-network" benefits; and
- benefits for "out-of-network" providers.

Spectera's participating provider network includes private practice optometrists, ophthalmologists and retail chains (includes most of the Wal-Mart stores in Georgia). When you make an appointment with a network provider, ensure that they still are participating in Spectera's network. Then identify yourself as eligible through the State of Georgia Flexible Benefits Program Spectera Vision Plan and provide your (employee's) social security number along with the patient's date of birth.

If you receive covered services from a network eye care provider, you will receive the benefits shown in the chart on page 20. You will not be required to file a claim, but will be responsible at the time of service for any co-payments and the cost of any non-covered service or equipment.

If you receive care from an out-of-network provider, you pay the full cost at the time of service and submit a receipt to Spectera to be reimbursed for covered out-of-network benefits. Receipts must be submitted together for services and materials purchased on different dates to receive reimbursement. Mail your itemized receipts, with your Social Security number, patient's name and patient's date of birth to:

Spectera Claims Department
P.O.Box 30978
Salt Lake City, UT 84130

If you have any questions about your vision care plan option, please contact Spectera's customer service at 1-800-638-3120.

Important to Remember
- Certain standard contact lenses, including daily wear, and up to 4 boxes of standard single vision disposable contacts are covered in full for your co-payments. If you purchase contacts that are not among Spectera's "covered in full" selection, you will receive an annual $105 allowance toward the purchase of contact lenses, and professional fees (i.e., fit and follow-up). Please note: To receive the full $105 allowance, you must receive your exam, fitting and evaluation at a single visit to the same network provider (at Wal-Mart, $70 of the $105 allowance is allocated to materials and $35 to professional fees). The allowance will only apply to one purchase per plan year. You must submit all receipts at the same time. Any balance remaining and not used during the plan year when the purchase occurred will be forfeited.

- Spectera covers standard single vision and standard lined multi focal lenses for glasses. Cosmetic lens options such as tinting, UV coating, progressive lenses, etc., are not covered, but are provided to Spectera's members at a savings below normal retail charges.

- Always verify coverage by identifying yourself as a Spectera member under the State of Georgia plan when making your appointment. Give the provider the employee's social security number, patient's name and the patient's date of birth. Benefits are provided every 12 months for exams, lenses and/or contacts and every 24 months for frames measured from the last date of service.

Medically Necessary

A member qualifies for medically necessary contact lenses if Spectera establishes that an eligible member has any of the following:
- Keratoconus or irregular astigmatism;
- Anisometropia of 3.50 diopters or more;
- Post cataract surgery without intraocular lens; or
- Visual acuity in the better eye of less than 20/70 with spectacles, but better than 20/70 with contacts.

Exclusions

The Vision Plan does not cover:
- replacement of lost lenses or frames
- medical or surgical treatment of eye conditions
- amounts above the schedule of benefits or allowances
- services or materials not included as eligible expenses by the Vision Plan
- cosmetic extras such as no line multifocal lenses, tints, UV coatings etc.

Vision Coverage Chart

Service	In-Network Benefits	Out-of-Network Benefits
Routine Eye Exam Every 12 months	Covered after $10 co-pay	Reimburses up to $40
Lenses Standard Every 12 months, if prescribed	Covered after $20 materials co-pay	
Single vision, or		Reimburses up to $30
Lined Bifocal, or		Reimburses up to $45
Lined Trifocal, or		Reimburses up to $60
Lenticular		Reimburses up to $80
Frames Every 24 months after a $20 materials co-pay*	Retail locations (Wal-Mart) • Up to $130 retail allowance toward any frame package • Frames below $130 provided at no additional cost Private Doctors Office • $50 wholesale allowance towards any frame. You pay the difference. • Group of select frames at no additional cost	Reimburses up to $45 of retail
Contact Lenses Every 12 months in place of eyeglasses		
Medically Necessary**	Covered after $20 materials co-pay	Reimburses up to $200
Not Medically Necessary	Covered after $20 material co-pay for covered lenses selected from Spectera list. Up to four boxes of covered disposable contact lenses are included when using a network provider. All other contacts available through a $105 allowance that includes fitting, follow-up and materials. Please note to receive the full $105 credit, you must receive your exam, fitting evaluation and all contact materials at the same provider at the same time. (At Wal-Mart $70 of the $105 allowance is allocated to materials and $35 to professional fees).	Up to $105 max that includes fit, follow-up
Refractive Eye Surgery Spectera participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States.	Discount only: The in-network benefit is a discount off the full retail price. To find a participating laser eye surgeon in your area, visit our website at www.spectera.com	No benefits

⦿ Remember: If you use in-network providers, you are responsible only for your portion of cost. If you decide to use a non-network provider, you pay everything and seek the out-of-network benefits payments schedule.

* Only a one time $20 material co-pay applies per benefit period.
**As defined herein (on page 19)

Health Savings Account and Spending Accounts

HEALTH SAVINGS ACCOUNT (HSA)

Health Savings Accounts (HSAs) are tax-exempt savings accounts, and allow you to save for current or future health care expenses. For enrollment in the Flexible Benefits Program, the HSA is available to you if you are:

- enrolled in the State Health Benefit Plan High Deductible Health Plan (HDHP);
- are not enrolled in Medicare;
- are not covered by another health plan; and
- are not claimed as a dependent on someone else's federal tax return.

Through HSA contributions, you can save, invest, and distribute funds on a pre-tax basis for qualified health expenses not otherwise covered by health insurance. While funds in the HSA are not subject to forfeiture and can be carried year to year, the HSA may not be right for all employees in an HDHP. The benefits, as well as the limitations, should be read and understood carefully.

Important features of the HSA:

- Annual maximums:

	HDHP Deductible	Maximum HSA Deposit (2008)
Single Coverage	$1,100	$2,900
Family Coverage	$2,200	$5,800

- Additional contributions can be made through deposits that you or someone else makes directly to the HSA, subject to annual maximums.
- Payroll contributions will begin the month in which your account becomes effective, but not before the effective date of your HDHP.
- Payroll contributions for PeopleSoft agencies may be delayed up to 15 days before posting to the account due to the receipt of funds by SPA and the reconciliation process by the TPA and bank.
- Payroll contributions for non-PeopleSoft agencies may be delayed up to a 30-day period before posting to the account due to the receipt of funds by SPA, the manual reconciliation process of payroll and the reconciliation process by the TPA and bank.
- Unlike the General Purpose or Limited Purpose Health Care Spending Account (HCSA), HSA contributions are not accessible for use until the money has been transmitted and posted to the account.
- If you are 55 or older, you may contribute additional dollars up to $900 as "catch up" contributions for 2008.
- Rollover amounts from another HSA are not subject to annual contribution limits, and must be deposited within 60 days after receipt of funds. Only one rollover contribution may be made to an HSA during any one-year period.
- Once you reach the investment threshold of $2,000, you may transfer funds into selected investment options offered through J.P. Morgan Chase & Co. A balance must be maintained in your deposit account. If the balance in the account remains $0 for over 60 days, it may be closed due to insufficient funding to pay monthly fees. (Fees may apply).
- Investment transfers, changes in beneficiaries, or changes in contribution amounts can be made at any time during the year.

You will be assessed a $3.00 monthly service charge for the administration of the HSA, which will be directly deducted from your Health Savings Account. If you leave employment with the State, you may retain your HSA, through J.P. Morgan Chase & Co., for a new monthly charge of $5.00. Other applicable transaction fees may apply. See the chart below for detailed HSA fees.

Service	Fee Detail	Fee
Monthly Service Charge	per account per month	$3.00
Debit Card	per card	none
Additional Debit Card	per card	$5.00
Replace Lost or Stolen Debit Card	per request	$15.00
Debit Card Transaction at Merchant Location	per transaction	none
ATM Cash Withdrawals	per transaction	$1.00
Over-the-Counter Teller Withdrawals	per transaction	none
Checks (25 check per book)	per request	none
Additional Checks (25 checks per book)	per request	none
Checking Writing	per check processed	$1.25
Stop-Check Service	per request	$20.00
Duplicate Check	per request	$10.00
Returned Deposit Check or EFT	per returned item	$10.00
Nonsufficient Funds	per transaction	$20.00
Rollover	per account	none
Account Closing	per account	$25.00

IMPORTANT NOTE: Under IRS rules, employees may not participate in a Health Savings Account and a General Purpose Health Care Spending Account (HCSA) at the same time. The General Purpose HCSA is considered a health plan that constitutes "other health coverage," making it impermissible for the employee to make contributions to the HSA.

An individual that participated in the HCSA (employee or spouse of an employee) for the immediate preceding plan year and who is covered by a "grace period," is not

eligible to contribute to the HSA until the first day of the first month following the end of the grace period, if there is a balance in the HCSA on December 31st. For example, the Flexible Benefits Program HCSA grace period ends March 15, 2008. If a participant has a balance in the HCSA on December 31st, and does not elect coverage by a general health care account or other disqualifying coverage for 2008, the employee is eligible for the HSA on April 1, 2008.

If a participant's health care spending account has no unused contributions remaining at the end of the immediate preceding plan year (December 31st), the employee may participate in the HSA and the Limited Purpose Health Care Spending Account, effective January 1, 2008.

SPENDING ACCOUNTS

Spending accounts are like getting a tax rebate every time you pay for health care and child or other dependent care expenses, since your pay goes into the accounts before taxes are withheld. This can mean savings of approximately 26%-45%, depending on your tax situation!

For the 2008 Plan Year, the spending accounts being offered are:

	Limited Purpose Health Care Spending Account (Dental and Vision only)	General Purpos Health Care Spending Account	Dependent (Child) Care Spending Account
Annual Maximum	$5,040	$5,040	$4,992
Annual Minimum	$ 120	$ 120	$ 120

- **Limited Purpose Health Care Spending Account (HCSA) – Dental and Vision Only**

  The Limited Purpose HCSA has been created specifically for those individuals who are choosing to enroll in the Health Savings Account (HSA) option. While enrollment in the General Purpose HCSA would prevent you from being eligible to participate in the HSA, enrolling in the Limited Purpose HCSA will allow you to continue to be deemed eligible to participate in the HSA, allowing you to save tax dollars on the dental and vision treatment you and your family receive.

  The IRS rules and the rules of the Employee Benefit Plan Council designate eligible expenses for the Limited Purpose HCSA. The Employee Benefit Plan Council has the responsibility to interpret these rules and make all decisions as to an expense's eligibility.

  Some of these eligible expenses include:
  - Expenses, deductibles and co-payments not paid by any dental or vision insurance in which you or your family members participate;
  - Costs for procedures not covered or not covered fully by a dental or vision plan;
  - Specialized equipment for disabled persons relating to dental or vision work;
  - Contact lens, glasses, and laser eye surgery;
  - Certain other IRS approved expenses relating to dental or vision work.

  Limited Purpose Health Care Spending Account (HCSA) Exclusions List

  These are a few examples of health care expenses that are not eligible for reimbursement under the Limited Purpose HCSA:
  - Any expense relating to a non-dental or non-vision expense
  - Insurance premiums
  - Postage/handling fees
  - Teeth whitening/bonding
  - Vitamins

  For further information on potentially eligible expenses, see IRS Publication 502, available at your personnel/payroll office, your local public library or IRS office, or online at www.irs.gov/prod/forms_pubs/pubs/pubs.html. Most, but not all, of the dental and vision expenses are reimbursable under the Limited Purpose HCSA.

- **General Purpose Health Care Spending Account (HCSA)**

  The traditional Health Care Spending Account, or General Purpose Health Care Spending Account (HCSA) helps you save tax dollars on the health-related treatment you and your family receive.

  Like the Limited Purpose HCSA, the IRS rules and the rules of the Employee Benefit Plan Council designate eligible expenses and the Employee Benefit Plan Council has the responsibility to interpret these rules and make all decisions as to an expense's eligibility.

  Unlike the Limited Purpose HCSA, the General Purpose HCSA, is not limited to only dental and vision expenses. Some of the eligible expenses for the General Purpose include:
  - Deductibles and co-payments not paid by any health or dental insurance in which you or your family members participate;
  - Costs for procedures not covered or not covered fully

To better understand the differences between the General Purpose HCSA, Limited Purpose HCSA, and the Health Savings Account (HSA), please see the comparison chart below.

Comparison Chart		
General Purpose Health Care Spending Account	Limited Purpose Health Care Spending Account	Health Savings Account (HSA)
Do not have to be enrolled in a HDHP or have health coverage at all	Same as General Purpose HCSA Intended to be used with the HDHP and a Health Savings Account	Must be enrolled in the State Health Benefit Plan (SHBP) High Deductible Health Plan (HDHP)
Distributions cover qualified medical expenses as defined under Section 213 (d) of the Internal Revenue Code	Distributions cover only qualified dental and vision expenses as defined under Section 213 (d) of the Internal Revenue Code	Distributions cover qualified medical expenses as defined under Section 213 (d) of the Internal Revenue Code and certain other expenses (LTC and COBRA premiums)
*Debit Card is available at no charge. Claims can be filed for reimbursement.	*Same as General Purpose HCSA	*Debit Card is available at no charge. If debit card not used, checks are available for a fee. No claims are filed.
The employee funds the account on a pre-tax basis (up to a maximum of $5,040) through monthly election.	Same as General Purpose HCSA	The employee funds the account on a pre-tax basis, up to a maximum of of $1,100 (single) and $2,200 (family) through monthly election and catch up contributions.
The annual amount the employee elects is available on the first day of coverage, regardless of the amount contributed by the date of the reimbursement request.	Same as General Purpose HCSA	Only the amount of the actual account balance is available for reimubursement.
Unused balances are forfeited. Expenses must be incurred by March 15th of the following plan year or by termination of employment, if before the end of the aforementioned benefit period.	Same as General Purpose HCSA	Unused balances are not forfeited and are carried from year to year.
The account cannot be taken with you upon termination, unless the employee is transferring between entities participating in the Flexible Benefits Program.	Same as General Purpose HCSA	The employee owns the account and keeps the account even if he/she changes health plans or terminates/retires.
No investment options available and interest does not accrue.	Same as General Purpose HCSA	Investment options are available with a minimum balance and interest accrues on a tax-free basis.
IRS regulations require that each claim be substatiated.	Same as General Purpose HCSA	Proof of expenses is not required, but the employee should be prepared to substantiate expenses to the IRS upon request.
Limited Changes can be made to contribution amount based on Qualifying Change in Status Event.	Same as General Purpose HCSA	Contribution can be started, stopped or changed at any payroll period on a prospective basis.
No tax forms to submit. Pre-tax amounts are shown on W-2.	Same as General Purpose HCSA	Tax forms 1099 SA and 5498 5A are sent to employee for filing in addition to W-2

**The Debit Card is the same for the Limited or General Purpose Health Care Spending Account (HCSA). If an employee had the General Purpose last Plan Year and enrolls for the Limited or General Purpose HCSA this Plan Year, they should keep the Card and not destroy it. If the Health Savings Account (HSA) is selected, a separate card will be issued. The two cards will be identified by separate colors and headings, "SHPS Flexible Spending Account Card" and "SHPS Health Savings Account Card."*

➢ ***2½ Month Grace Period for Limited & General Purpose Health Care Spending Account (HCSA)***
Employees have an additional 2½ months to spend the money in their General or Limited Purpose Health Care Spending Account. This means qualified expenses may be reimbursed for services provided through March 15, 2009. Employees will have until May 31, 2009 to send their claims to SHPS for reimbursement. Remember, if a claim is mailed, the envelope must be postmarked by May 31st. The fastest way to get claims to SHPS is to fax them at 1-866-643-2219.

To best take advantage of this grace period, plan only for expenses you expect to have for the 12 month period. If you do not use all of the money you contributed, you can then use it in the grace period.

➢ ***Keeping Receipts***
Remember, for the HCSA (General or Limited) you must keep your receipts since some transactions may require validation by SHPS. For the HSA, proof of expenses is not required, however, you should be prepared to substantiate expenses if requested by the IRS. You must always submit receipts for over-the-counter purchases made with the card.

➢ ***Go on-line with MySHPS at www.shps.com*** *to access web tools, tax savings worksheets, tax savings calculators, claim forms, direct deposit forms, and check your account status. By providing your e-mail address, you may also receive routine correspondence via e-mail from SHPS about your account.*

➢ ***Call SHPS AccountLink toll-free at 1-800-893-0763.*** *Use the automated phone system to find out your current account balance(s) and the status of your last claim. You may talk with a SHPS customer service counselor by staying on the line or pressing the (*) key. AccountLink is available 8:00 a.m. - 2:00 a.m. Eastern time, Monday - Friday. Benefit Counselors are available 8:00 a.m. - 8:00 p.m. Eastern time, Monday - Friday.*

➢ ***Fax Spending Account Claims to 1-866-643-2219.*** *If your email is on file with SHPS, you will receive confirmation of your faxed claim and notification once your claim is processed.*

➢ ***The Debit Card***
When you enroll in the Health Savings Account or Health Care Spending Account (Limited or General Purpose) program, you'll receive a VISA® Savings and/or Spending Account Card for purchases of eligible healthcare expenses. You will automatically receive the Card, along with information about the card and how it can be used. You may request up to 4 additional cards with your spouse or dependent's name on it, for a fee of $5.00 per card. If your card is lost or stolen, you may request another card for a fee of $15.00. For additional cards, call SHPS at 1-800-893-0763.

NOTE: If you use your debit card during the grace period, the expenses will be paid from your 2007 HCSA balance. If you have a balance in your 2007 HCSA account, SHPS will perform a "true-up" after May 31st. Once the "true-up" has been completed, SHPS will transfer the funds from your 2008 HCSA balance and you will be able to receive reimbursement for your 2008 expenses. ***If you have a balance in your prior month's account, it is recommended that, during the grace period, you submit paper claims marked "2007 expenses".***

by a health, dental or vision plan;
- Specialized equipment for disabled persons;
- Preventative care screenings;
- Contact lens and glasses;
- Laser eye surgery;
- Prescription and over-the-counter medicine;
- Mental health services;
- Physical therapy; and
- Certain other IRS approved expenses.

General Purpose Health Care Spending Account (HCSA) Exclusions List
These are a few examples of health care expenses that are not eligible for reimbursement under the General Purpose HCSA:
- Cosmetic procedures/drugs
- Electrolysis
- Hair transplants
- Herbal supplements
- Insurance premiums
- Nicotine patches and gum
- Nutritional supplements
- Postage/handling fees
- Teeth whitening/bonding
- Vitamins

NOTE: You may not participate in the General Purpose HCSA and the HSA at the same time.

For further information on potentially eligible expenses, see IRS Publication 502, available at your personnel/payroll office, your local public library or IRS office, or online at www.irs.gov/prod/forms_pubs/pubs/pubs.html. Most, but not all, of these expenses are reimbursable under the General Purpose HCSA.

- **Dependent (Child) Care Spending Account (DCSA)**
  The Dependent (Child) Care Spending Account provides you with the opportunity to use tax-free dollars to pay for the care of your children under age 13 or other IRS eligible dependents while you and your spouse work or go to school full time.

The IRS rules and rules of the Employee Benefit Plan Council designate eligible expenses for the Dependent Care Spending Account. The Employee Benefit Plan Council has the responsibility to interpret these rules and make all decisions as to an expense's eligibility. **Please note that the DCSA does not reimburse for any medical expenses. For medical reimbursements for all family members, select the HCSA (General or Limited).**

Childcare services may include your cost to send a child to preschool, after school, or nursery school. Also, expenses for dependents of any age who are unable to care for themselves because of a physical or mental handicap are eligible. A person qualifying for this type of care must spend at least eight hours a day in your home. Elderly dependent care may include your cost to send a dependent parent to an elderly daycare facility or to have someone to care for them in your home.

If you are married, both you and your spouse must be working or a full-time student during the time the care is received. Your income tax return (long and short forms) will require you to include your dependent care provider's name and tax number or Social Security number.

Dependent (Child) Care Spending Account Exclusions List

These are a few examples of dependent care expenses that are not eligible for reimbursement:

- Activity and book fees
- Child support payments
- Cleaning and cooking services not provided by the care provider
- Custodial nursing care
- Field trips
- Food, clothing, and entertainment
- Late payment fees
- Kindergarten
- Long Term Care premiums
- Overnight camps
- Sports lessons
- Transportation to and from the child care provider
- Tuition to private school

NOTE: The Economic Growth and Tax Relief Reconciliation Act (EGTRRA) of 2001 increased the amount of the employment-related expenses that may be taken into account for a taxable year to $3,000 for one qualifying individual and $6,000 for two or more qualifying individuals. This increase applies to the Dependent Care Tax Credit only and not the Dependent (Child) Care Spending Account.

- An employee who is a single parent filing as head of household with one child and $3,000 of dependent care expenses may have better tax savings using the dependent care tax credit instead of participating in the Dependent Care Spending Account.
- The single parent above with one child and more than $3,000 of dependent care expenses may have better tax savings with the Dependent Care Spending Account since the limit is $4992 rather than the $3,000 for the tax credit.
- If there are two or more children with $6,000 in dependent care expenses, the employee could utilize both the dependent care tax credit and spending account by electing $4,992 through the spending account and claiming $1,008 through the tax credit.
- However, the rules for coordinating the dependent care tax credit and spending account do not permit the reverse.

Example: Assume an employee is a single parent and has $5,000 in dependent care expenses. The employee could not use the $3,000 dependent care tax credit and put $2,000 in the spending account. This would cause the spending account benefit to reduce the expenses eligible for the dependent care tax credit from $3,000 to $1,000 because taking the exclusion under the spending account phases out the dependent care tax credit. You should carefully review your option of using the dependent care tax credit or using the Dependent Care Spending Account.

Everyone's situation is unique – it is very important that you consult a qualified tax advisor for assistance in determining if the dependent care tax credit, spending account, or a combination of the two is best for your situation.

Dependent (Child) Care Spending Account Limits

You may not be able to deposit the full $4,992 if any of the following situations apply to you.

- If your spouse works for the State or another employer who offers a similar plan, the total of your family's contributions to a dependent (child) care spending account cannot exceed $4,992.
- If either you or your spouse earns less than $5,000 a year, you can deposit as much as the smaller of your two incomes.
- If your spouse is either a full-time student or incapable of self-care, you may deposit up to $3,000 for one dependent, or $4,992 for two or more dependents.
- If you are married but file a separate federal income tax return, you may deposit a maximum of $2,500 to your dependent (child) care spending account.
- If you are hired after January 1 or have a qualified change in status during the plan year (see Terms and Conditions in front of this booklet), you may contribute up to $416 per month for the remainder of the plan year.

Important Information About Health Care and Dependent (Child) Care Spending Accounts

There are some important things to keep in mind when deciding how much money to put into your spending accounts.

- For Plan Year 2008, Spending Account reductions from your paycheck begin December 14 for coverage effective January 1.
- If you are hired mid-year or have a qualified change of status during the year (see Terms and Conditions in front of the enrollment booklet), you may not contribute the maximum allowed under each account for the remainder of the plan year. You may only contribute the maximum per month allowed to each account.
- Reductions for spending accounts are made every pay period. But remember to enter the **monthly** amount you want to contribute on your web Option Statement.
- Your spending account enrollment is binding for the plan year. You may be able to make limited changes if you have a qualified status change.
- You cannot carry over expenses that you have incurred in one plan year into the next plan year for reimbursement.
- Claims should only be submitted **after** services have been provided.
- You may submit claims at any time for any amount, but payment will not be made until your claims total $25 or more. Reimbursement may be by check or by direct deposit to your bank account.
- You receive a bi-monthly statement showing how much you have in each account.
- You cannot transfer money from one account to another.
- Reimbursements are issued on a daily basis.
- Spending account claims for the 2007 Plan Year (January1 - December 31, 2007) must be faxed or mailed with correct documentation and postmarked on or before May 31, 2008. Claims postmarked after May 31st will not be paid.
- Spending account claims for the 2008 Plan Year (January 1 - December 31, 2008) must be faxed or mailed with correct documentation and postmarked by May 31, 2009.
- Under IRS rules, any money left in your accounts and not claimed for the previous plan year's expenses by the claim filing deadline is forfeited. It is retained by the plan and used for administrative expenses.

A Word About Forfeitures

By putting money into your spending accounts, you can save approximately 26%-45% in taxes for eligible expenses. Many employees say they don't use the spending accounts because they are afraid of forfeiting money, although few employees actually do. Although there is a possibility of forfeiting money, consider your tax savings. For example, an employee with an annual salary of $22,000 and spending account contributions of $2,000 could potentially save $580. If this same employee forfeits $55, he still saved $525.

If You Leave or Retire

If you terminate or retire from State employment during the plan year, your General or Limited Purpose Health Care Spending Account coverage stops with the end of the month following the last full month of employment or contribution. For example, if you terminate employment on August 31, your last contribution to your HCSA would be taken from your August 31 paycheck. Your coverage would end September 30, because contributions deducted from your paycheck in one month provide coverage for the following month. If you submit a claim for expenses incurred on or after October 1, your claim would not be paid.

If you have contributed more to the Health Care Spending Account than you have been reimbursed for on the date you leave or retire, your coverage may be extended temporarily under COBRA. The Dependent Care Spending Account cannot be continued under COBRA, however, you may continue to file claims for eligible expenses if you have an available balance upon termination.

Contact the Flexible Benefits Program at 404-656-2730 or 1-888-968-0490 for more information.

Important Information to consider if you are selecting the Health CDHP Plan with an HRA and a Health Care Spending Account (HCSA). Plan your expenses carefully, since you will be required to use your HRA funds before you can be reimbursed from your HCSA.

Employee Spouse and Child Life Insurance and AD&D

- **Employee Life Insurance**
  If you want life insurance protection or you want to supplement the protection you already have, you may choose group term life coverage under the Flexible Benefits Program.

You may choose coverage equal to:
- one times your pay (maximum coverage is $250,000)
- two times your pay
- three times your pay
- four times your pay
- five times your pay
- six times your pay
- seven times your pay

The coverage maximum is $500,000.

The life insurance amount you choose will be based on your Benefit Salary as of October 1, 2007. This amount is rounded up to the next higher $1,000, after you multiply your coverage and the premium has been adjusted for your October 1, 2007 pay and age. If you are age 65 or older, the value of your life coverage is reduced.

The premium cost for life insurance is based on your age, salary, and on the amount of coverage you choose. You may pay your premiums with pre-tax or after-tax dollars if you choose coverage over $50,000. If you have over $50,000 of life insurance coverage, it's worth knowing that:
- the extra "value" of your coverage will be shown as "imputed income" on your W2 statement, and you will also pay FICA taxes as well on "imputed income."
- the extra taxes you may owe will be minimal… and the tax savings using pre-tax premiums will be greater than any "imputed income" tax withheld, unless you earn over $100,000 and are over age 65.

In any case, if you elect over $50,000 of coverage you have the option to pay for life insurance with after-tax premiums and avoid imputed income. If you wish to elect after-tax premiums, indicate your choice on your Option Statement.

How Employee Life Insurance Works
The life insurance amount you choose is paid to your beneficiaries if you die while this coverage is in effect. Your beneficiaries are the persons you name to receive your life insurance benefits.

If you are choosing life insurance for the first time, name your beneficiaries by completing the Flexible Benefits Program Beneficiary Election Form, and file it with your personnel office. You can change your beneficiaries anytime by completing a new form.

Whenever you enroll or change your life insurance coverage, be sure to check the Life Medical Underwriting process so you will know what will be expected. These processes are described on pages 8 & 9.

- **Spouse Life Insurance**
  If you choose employee life insurance for yourself, you may also choose spouse life insurance coverage for your spouse. Your spouse is eligible for coverage if you are not legally separated or divorced. Spouse life insurance premiums are based on the coverage level and employee age. These premiums for spouse coverage are after-tax. You may choose $6,000, $12,000, $30,000, $60,000, $100,000, $150,000, $200,000 or $250,000 spouse coverage levels. However, if you are age 65 or older, the value of your spouse life coverage is reduced.

  Spouse Life coverage cannot exceed 100% of your amount of Employee Life coverage.

  You are the beneficiary of Spouse Life insurance coverage and will receive the insurance benefit in the event of your spouse's death.

Available Coverage Amounts

Spouse Life	- $ 6,000	- $ 12,000	- $ 30,000
	- $ 60,000	- $100,000	- $150,000
	- $200,000	- $250,000	

- **Child Life Insurance**
  If you choose life insurance for yourself, you may also choose child life insurance coverage for your child(ren). Child life insurance premiums are after-tax.

  Your children are eligible for coverage if they are:
  - Unmarried, dependent on you for support and under age 19.
  - Unmarried and a full-time student under age 26.

Points to Remember:
- For the $3,000, $6,000, $10,000, $15,000 or $20,000 child coverage levels, the child coverage can begin at live birth. Coverage from live birth to 6 months is the lesser of the elected amount or $6,000.
- Child Life coverage cannot exceed 100% of your amount of Employee Life coverage. Physically and/or mentally handicapped children covered under Child Life may continue to be covered beyond the age of 19.
- You are the beneficiary of child life insurance coverage and will receive the insurance benefit in the event of the child's death.

Available Coverage Amounts

Child Life	- $ 3,000	- $ 6,000	- $ 10,000
		- $ 15,000	- $ 20,000

For information regarding conversion and portability of your Employee Life, Spouse Life, and Child Life insurance, contact Minnesota Life Insurance toll-free at 1-800-660-2519.

Enrolling For Coverage

If your coverage selection requires medical underwriting, you will need to complete the Minnesota Life Evidence of Insurability Form along with any other required information. An approval by Minnesota Life, the insurance carrier, must be made before coverage can be in effect.

If you are a newly eligible employee, you may elect $30,000 or less of spouse life coverage and/or any coverage of child life without completing the medical underwriting process.

If you have any questions, call the Flexible Benefits Program at 404-656-2730 or toll free at 1-888-968-0490.

- **Accidental Death and Dismemberment Insurance**
  The Flexible Benefits Program lets you decide if you want accidental death and dismemberment (AD&D) insurance.
  You may choose coverage equal to:
  - one times your pay
  - two times your pay
  - three times your pay
  - four times your pay
  - five times your pay
  - six times your pay
  - seven times your pay

  The coverage maximum is $500,000.

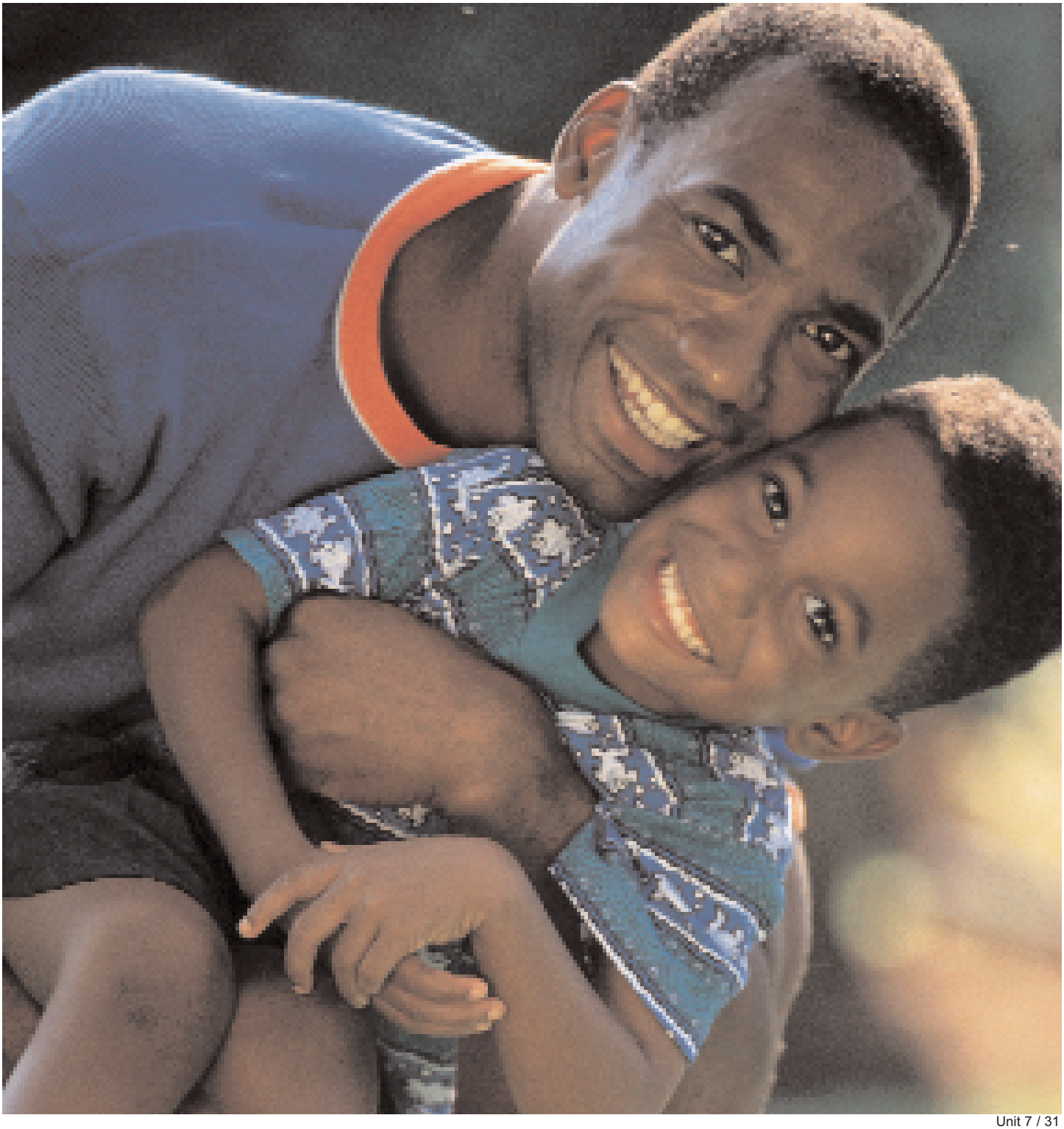
In general for the AD&D insurance to be paid to you or your beneficiary, your death or injury must be the result of a covered accident. In case of permanent and total disability, you are eligible for AD&D benefits if your injury prevents you from working at any job for which you are qualified by education, training, or experience.

Enrolling For Coverage

Your cost depends on how much AD&D insurance you choose. As with life insurance, your coverage will be based on your Benefit Salary as of October 1, 2007. This amount is rounded to the next higher $1,000, after you multiply your pay by your election. If you are age 75 or older, the value of your coverage is reduced.

The beneficiaries you name for life insurance are also your beneficiaries for AD&D insurance. If you are not enrolled in life insurance, be sure that you complete the Flexible Benefits Beneficiary Election Form to name your beneficiaries. You can change your beneficiaries anytime by completing a new form. Be sure to return the completed form to your personnel office.

Disability



To help provide income protection against the unexpected, the Flexible Benefits Program allows you to choose:

- short-term disability insurance and/or
- long-term disability insurance.

• Short Term Disability

Short-Term Disability Protection

If you choose short-term disability (STD) coverage, this plan will work with other income benefits to replace 60% of your Benefit Salary (in effect during the Plan Year the disability began) up to $800 per week. Other benefits include Social Security, workers' compensation, any other governmental disability programs, any other group disability plans including the State retirement systems, or special injury benefits you are eligible to receive. If these other benefits total more than 60% of your Benefit Salary, the short-term disability plan will not pay for this disability.

How STD Works

In general:

- If your claim is approved by the insurance company, you are eligible to receive short-term disability benefits after you have been disabled for 30 continuous calendar days or 7 continuous calendar days depending on the coverage level you have chosen.
- A late enrollment penalty may apply for late entrants to the STD plan (employees who do not elect STD when first eligible).
- You may choose whether to use sick leave or receive these benefits. You cannot receive these benefits and sick leave at the same time. You may, however, decide to receive these benefits and save your sick leave for future use.
- Your short-term disability benefits are calculated on the Benefit Salary that is in effect during the Plan Year your disability began, less other income benefits. For example, if your first day of disability is December 3, 2007, your disability benefit will be calculated on the Benefit Salary reflected on your 2007 Option Statement, not your 2008 Benefit Salary.
- Your short-term disability benefits can continue until you recover, return to work, or receive benefits for a maximum of 150 calendar days or a maximum of 173 calendar days, depending on the coverage level you have chosen. The calendar-day maximums are reduced by any days of paid sick leave, donated leave or Special Injury Leave that you use which exceeds the applicable wait period.
- When changing from the 30-day Benefit Waiting Period to the 7-day Benefit Waiting Period, a Pre-Existing clause is applicable. If you have a condition for which you should have sought medical care or which originated prior to the 7-day Benefit Waiting Period effective date, you will be subject to the rules of the 30-day Benefit Waiting Period until you are on the plan for 12 consecutive months. The Pre-Existing clause does not apply to accidental injuries.

What Is A Late Enrollment Penalty For Late Entrants?

A current employee choosing coverage for the first time or re-enrolling after discontinuing coverage is considered a late entrant. If your STD Disability is caused by an accidental injury, benefits will begin after you have been disabled for 30 continuous calendar days or 7 continuous calendar days depending on the coverage level you have chosen after the benefit waiting period is satisfied for STD. However, for STD late entrants, who become disabled due to Physical Disease, Pregnancy, or Mental Disorder, during the 12-month period after the date your STD insurance becomes effective, benefits will not begin until after you have been disabled for 60 days until you are on the plan for 12 consecutive months. For STD late entrants whose disabilities begin after this 12 month period, benefits will start after the benefit waiting period (7 or 30 continuous calendar days) is satisfied for STD.

Enrolling For Short-Term Disability Coverage

Your premiums will be based on your coverage level and Benefit Salary. Since you pay for this coverage with after-tax premiums, you won't pay taxes on the benefits you receive.

• Long-Term Disability Protection

The Flexible Benefits Program's long-term disability (LTD) coverage works with other benefits you are eligible to receive, including Social Security, workers' compensation, other governmental disability programs, any other group disability plans including the State retirement systems, or any special injury benefits you are eligible to receive. The plan assures that your combined disability benefits from all these sources will equal 60% of your pay as shown on your Option Statement, up to $4,000 a month. The plan will pay at least $100 a month, even if your disability benefits from all other sources total more than 60% of your Benefit Salary, up to $4,000 a month, unless you are in an overpayment situation.

How Long LTD Benefits May Be Payable

These benefits will begin after you have been disabled for 180 calendar days and are reduced by any sick leave you use. Long-term disability benefits end when you are no

longer disabled or reach age 65, except benefits for disabilities caused by mental disorders, or other limited conditions (excluding schizophrenia, bi-polar or organic brain disease), which are limited to two years. If you become disabled after reaching age 60, however, your benefits could continue for a limited period after age 65.

For the first two years of your disability, you are disabled if you cannot perform your occupation, and earn less than 80% of your monthly Benefit Salary from your employer. After that, you are disabled if you are unable to perform, with reasonable continuity, the material duties of any occupation and cannot earn more than 60% of your monthly Benefit Salary from any employer.

Enrolling For Long-Term Disability Coverage
Your cost for long-term disability coverage is based on your age, your FICA Status, Benefit Salary, and whether or not you are eligible for disability coverage through any State of Georgia retirement plan, and/or through Social Security.

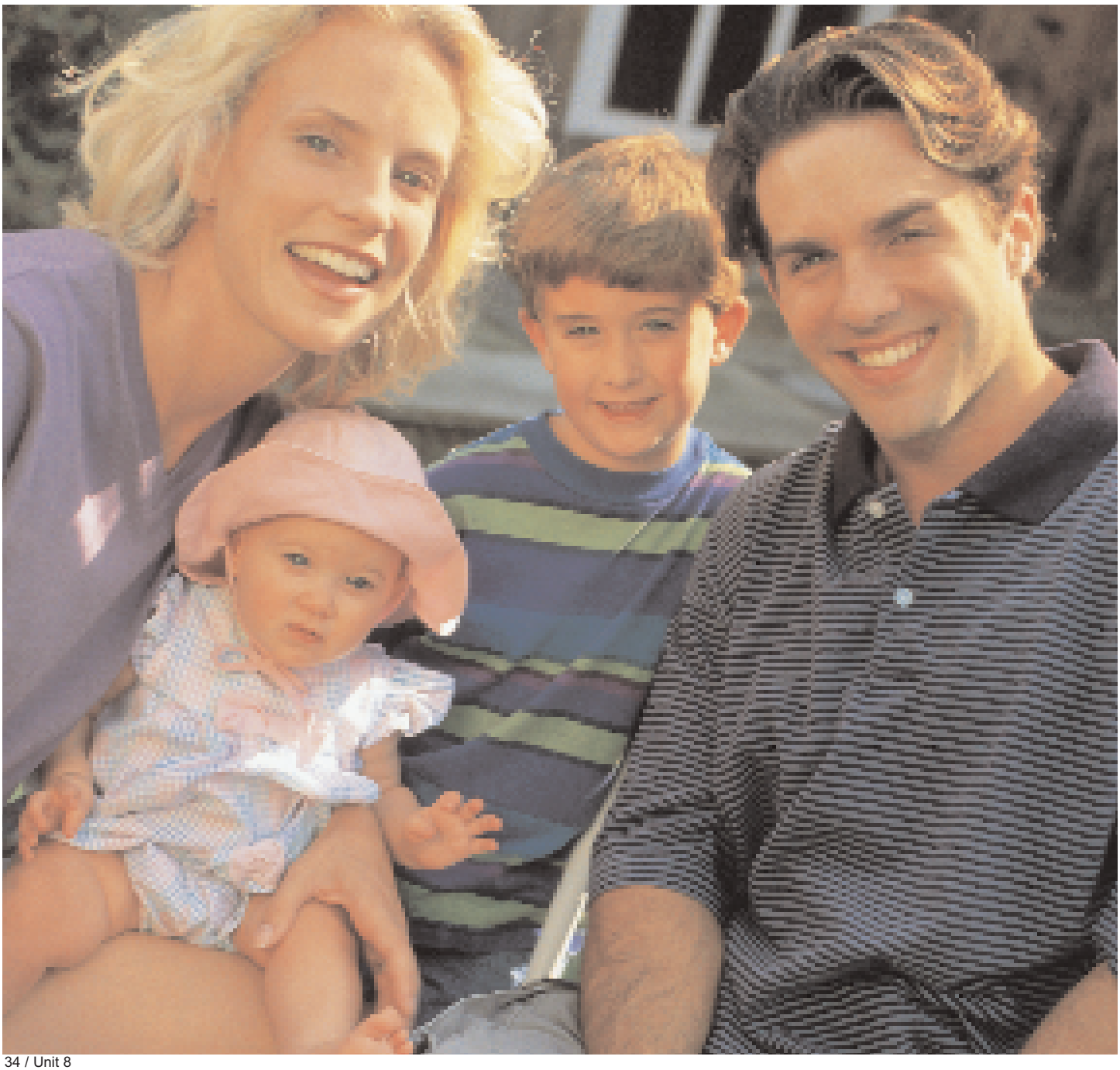
- Long-term disability premiums are paid with pre-tax dollars. The Internal Revenue Service (IRS) considers these benefits to be taxable income.
- If you become disabled and receive long-term disability benefits, you will be responsible for paying taxes on your benefits from this plan. However, since your income from disability benefits would be lower than your salary, you would owe less in taxes.

If you are selecting LTD insurance for the first time, see page 8 for the medical underwriting process.

Eligibility For An Early Disability Retirement
At total and permanent disability, some employees are eligible for early retirement through a State retirement system, as long as the disability is considered permanent. For the Employees' Retirement System, you may call 404-350-6300 for more information. For the Teachers' Retirement System, you may call 404-352-6500 or toll free at 1-800-352-0650.

If you have any questions about eligibility or how the short-term and long-term disability insurance plans work, call 1-888-641-7186.

Long Term Care



Long-Term Care
Long-term care refers to a wide range of personal care, health and social services for people of all ages who suffer a chronic disease or long-lasting disability. These services can be provided in a nursing facility, an adult day care center or at home, and can involve some nursing care. The cost for this kind of care is very high. Home care can be as much as $20,000 per year, and nursing home care can range in cost from $20,000 to $60,000 annually. Generally, you pay these expenses out of your own pocket, because medical insurance and Medicare do not cover long-term care. Typically, Medicaid is only available to members after they have significantly depleted their assets and income. Long-term care insurance is designed to protect you financially by paying benefits if you need long-term care. It also helps you maintain greater independence and a higher quality of life.

Did You Know…
- *Nearly half of all Americans over age 65 require long-term care for some period of time?*
- *Medical insurance and Medicare generally do not cover long-term care?*
- *Medicaid covers some types of long-term care, but restricts your choices of where this care can be provided?*
- *Many Americans will spend their life savings on less than one year of care?*

Your Long-Term Care Options
You can choose from one of three daily benefit levels and the corresponding monthly premium that is right for your needs and budget. The amount of the benefit depends on two factors: where the long-term care is provided - either in a nursing facility, or home/day/ assisted living facility - and the daily dollar level of the coverage you have selected. With any of these daily benefit options, benefits are paid on a monthly basis. The monthly benefit is equal to 100% of your elected daily benefit amount for care provided in a state-licensed nursing home facility, and 60% of your elected daily benefit amount for care provided in an assisted living facility or at home. If you wish, you can add on a reduced paid-up option and/or an inflation protection option.

Who Can Be Covered
This plan is offered to you, your spouse, your parents or your parents-in-law. "Parents" are biological (natural), adoptive, or step-parents of eligible employees or spouses. Your spouse, parents and parents-in-law will have to complete a medical underwriting process and be approved to be accepted for long-term care coverage. Your family members' premiums will be billed directly by the insurance company. Your payroll deduction will be for your individual coverage only.

When Benefits Are Paid
Benefits begin after a 90-day waiting period in which you or a covered family member has an eligible physical or cognitive disability. You qualify for benefits if the disability creates a need for you to receive continual help from another person to carry out any three of the following six activities of daily living:
- eating
- dressing
- bathing
- using the toilet
- transferring from a bed to a chair
- continence

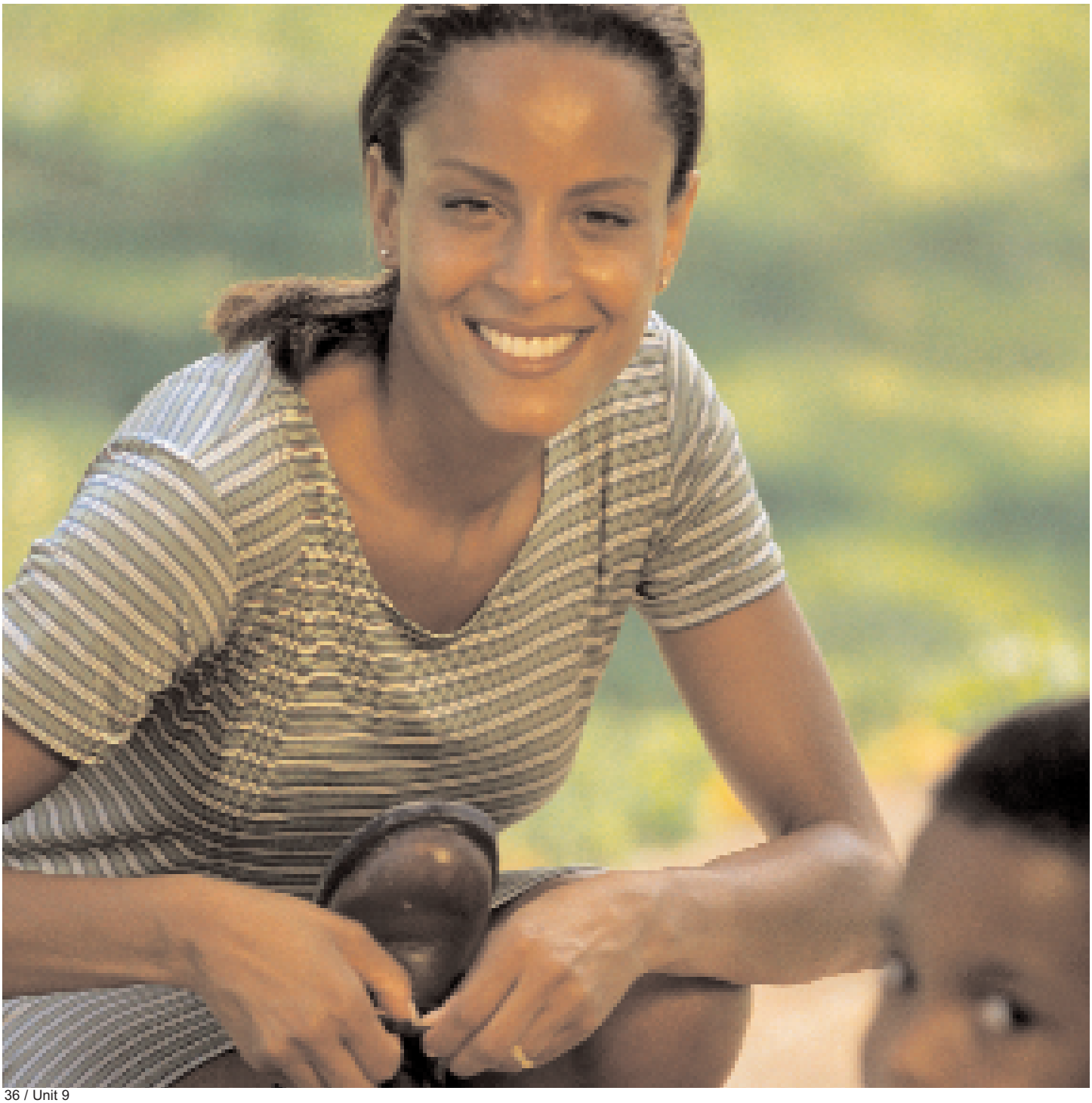
Benefits from long-term care insurance are not taxed when you receive them.

About Your Premiums and Enrolling
You pay for your long-term care coverage through the convenience of payroll deduction with after-tax dollars. Premium costs are based on your age as of the Benefit Calculation Date (October 1). Your family members' premiums are based on their age as of the date they apply for coverage. Their premiums will be sent directly to Unum, not deducted from payroll.

FOR THE PY 2008 OPEN ENROLLMENT ONLY, CURRENT EMPLOYEES MAY SELECT OR INCREASE LONG-TERM CARE WITH NO MEDICAL UNDERWRITING REQUIRED. At all other times, if you are a current employee and selecting long-term care insurance for the first time, or are currently enrolled and want to increase your benefit level or add options, or are re-enrolling after discontinuing coverage, check page 8 for medical underwriting requirements. As a newly eligible employee, you may select LTC with no medical underwriting required. For more information about long-term care coverage, call Unum at 1-888-SOG-FLEX (1-888-764-3539).

The long-term care plan can play an important part in your future. Coverage will stay in effect for as long as you continue to pay the monthly premium, even if you should leave the State's employment. You could then apply for coverage continuation and be billed by Unum directly at your home.

Specified Illness



SPECIFIED ILLNESS PLAN

With the group specified illness plan, our goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness or condition.

According to medical statistics:

- Over 1.3 million new cancer cases were expected to be diagnosed in 2005.[1]
- The National Institutes of Health estimated the overall costs for cancer in the year 2004 at $189.8 billion: $69.4 billion for direct medical costs and $120.4 billion for indirect costs.[1]
- An estimated 700,000 Americans were to have a new coronary attack in 2005. About 500,000 were to have a recurrent attack.[2]
  It was estimated that a stroke occurred every 45 seconds in 2005.
- The estimated direct and indirect cost of cardiovascular disease was $393.5 billion in 2005.[2]

The good news is that many people with a specified illness survive these life-threatening battles. Unfortunately, as the recovery process begins, people become aware of the medical bills that have piled up. Your recovery doesn't have to be spoiled by medical bills.

Plan Provisions

Employee coverage levels:

- $ 5,000 - No Medical Underwriting required for selection during the 2008 Plan Year Open Enrollment Period
- $10,000 – No Medical Underwriting required for selection during the 2008 Plan Year Open Enrollment Period
- $20,000 - Medical Underwriting required
- $30,000 - Medical Underwriting required
- $40,000 - Medical Underwriting required
- $50,000 - Medical Underwriting required
- Lump-sum benefits paid directly to the insured following the diagnosis of each covered specified illness after you are hospital confined for the specified illness and charged for room and board. (See the chart below for information on covered specified illnesses.)
- Rates cannot be individually increased due to change in age, health or individual claim.
- Simplified underwriting-answer only a few health questions.
- The plan is portable* - take your coverage with you if you leave your job.
- Available to employees age 18-69.
- Benefits for participants reduced 50% at age 70.

Spouse coverage levels:

- $5,000 benefit – No Medical Underwriting required for 2008 Plan Year
- Same plan design as employee
- Employee must have coverage for the spouse to have coverage
- Rates are based on employee age

Child coverage:

- Children covered at no additional cost
- All children are covered at 10% of employee benefit amount
- Children ages 0 – 24, if a dependent
- Child coverage automatically added to existing employee coverage

Covered Critical Illnesses*

Illnesses Covered Under Plan	Percentage of Face Amount
Heart Attack	100%
Stroke	100%
Major Organ Transplant	100%
Renal Failure (End Stage)	100%
Internal Cancer	100%
Carcinoma in situ**	25%
Coronary Artery	25%

*Certain stipulations apply to portability.

**A partial benefit (25%) is payable for carcinoma in situ and coronary artery bypass surgery. Payment of the partial benefit for carcinoma in situ will reduce the benefit for internal cancer. Payment of the partial benefit for coronary artery bypass surgery will reduce the benefit for a heart attack.

1. 2005 Cancer Facts & Figures, American Cancer Society
2. 2005 Heart and Stroke Statistical Update, American Heart Association

First Occurrence Benefit

After the Waiting Period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Additional Occurrence Benefit

If an insured collects full benefits for a Critical Illness under the plan and later has one of the remaining covered illnesses, then we will pay the full benefit amount for any additional illness. Occurrences must be separated by at least 6 months.

Re-Occurrence Benefit
If an insured receives full benefit for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months or 12 months treatment free for Internal Cancer.

Health Screening Benefits
An insured may receive a maximum of $50 for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the policy remains in force. This benefit is payable for the covered employee. The covered health screening tests include:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography

Legal Insurance

LEGAL INSURANCE

Everyday occurrences often require legal assistance, whether it's selling a home, establishing a will, defending a traffic ticket, or addressing a variety of other legal matters. Attorney fees can be costly, ranging from hundreds to thousands of dollars.

A recent study has shown that, in any given year, workers are 3 times more likely to be involved in a legal dispute than to be admitted to a hospital and 88% of workers surveyed experienced at least one legal event in a year.

The State of Georgia Flexible Benefits Program has offered the benefits of group legal services insurance for over 15 years. During that time, thousands of employees from the State of Georgia have taken advantage of this valuable resource and have been better able to afford qualified legal advice.

Legal advice is a need felt by all segments of the population and it is growing every year. It is for this very reason the value of a group legal services insurance plan is increasingly being recognized as one of the most helpful and responsible benefits of the decade.

Signature LegalCare® is proud to be a part of the GE Consumer Finance portfolio of products. With Signature LegalCare®, you have the freedom and flexibility to deal with debt collection defense, adoptions, divorce, wills, estate administration, and more. Experienced Participating Attorneys can answer many of your questions over the phone.

Signature LegalCare® is an insurance program that pays claims. In many instances, the Plan will cover the entire cost of your attorney fees when you use a Participating Attorney.

Elswick, Jill. 2000. "Legal Problems Impair Employee Effectiveness." Employee Benefit News. http://www.benefitnews.com.

Signature LegalCare® Benefits:

Additional Services

Telephone Advice. This benefit provides the opportunity for a Covered Person to discuss with an Attorney personal legal problems that are not specifically excluded under the Plan. The Attorney will explain the Covered Person's rights, point out his or her options, and, if needed, recommend a course of action. This service is available from Participating Attorneys located in any state. In addition, a Participating Attorney located in Georgia will make follow-up calls and send correspondence to third parties and will review simple legal documents. This service is available through an independent law firm referred to as the Preventive LegalCare Office (PLCO). The Covered Person will not be billed for this service, there is no limit to how often the service is used, and there are no claim forms to be completed.

Reduced Fee Benefit. For legal fees that are not otherwise covered by the Plan (e.g., the Covered Person's "Attorney Office Work" benefit is exhausted or the matter is not a paid-in-full benefit and the attorney fees have exceeded the Plan's maximum benefit amount), a Participating Attorney who elects to provide this benefit will charge his/her fees at a rate at least twenty five percent (25%) less than his/her usual and customary rate ("UCR"). Plan exclusions apply.

Maximum Contingent Fee Benefit. For any matter that is not otherwise covered by the Plan and for which a Participating Attorney who elects to provide this benefit normally charges a contingent fee (common for personal injury claims and other matters for which a Covered Person as a plaintiff anticipates being paid or awarded a large sum of money), the Participating Attorney will charge no more than the following maximum percentages:

- twenty five percent (25%) for all activities up to and including initial trial or settlement (including consultation and review)
- thirty percent (30%) for all activities relating to the appeal of an initial judgment, including appellate hearing and settlement

These limits apply to the attorney's fees, only, not to other costs not normally included as part of the Participating Attorney's professional fees. Plan exclusions apply.

Personal Law Center. The Personal Law Center is an online resource that is accessible through the Signature LegalCare Web site. It provides Covered Persons with unrestricted online access to a library of plain-English and easy-to-use legal and financial information, self-help forms, and interactive documents and tools.

In-Office Legal Services

The Signature LegalCare® plan makes in-office attorney visits easy! A Participating Attorney will provide you with advice on most covered legal matters with attorney fees paid –in –full. If there isn't a Participating Attorney in your area, Signature LegalCare will cover the services of

a Non-Participating Attorney on the same basis as for services provided by a Participating Attorney.

You may also choose to see a Non-Participating Attorney of your choice. For services provided by a Non-Participating Attorney, the Plan will reimburse you at a rate of $17.50 per quarter hour up to a maximum benefit amount. You are responsible for the balance of the attorney's fees. When covered services have been completed, file a claim form, including your attorney's billing statement, with Signature LegalCare. You'll receive direct reimbursement for the attorney's services, up to the maximum allowed by the Plan.

The Plan includes benefits for the following services:

- Administrative Hearings
- Adoptions
- Attorney Office Work (see "Note", below)
- Child Custody/Child Support
- Consumer Protection
- Debt Collection Defense
- Document Review and Preparation
- Estate Administration and Estate Closing
- Eviction Defense
- Guardianship/Conservatorship
- Immigration/Naturalization
- Internal Revenue Service Audit
- Juvenile Court Proceeding
- Matrimonial Matters
- Name Change
- Real Estate Matters
- Traffic Charges
- Wills and Trusts

NOTES:

You will have eight hours each year available to you under the "Attorney Office Work" benefit to use towards legal advice for non-covered services (except those legal matters which are specifically excluded).

For additional information on Signature LegalCare® benefits or if you have questions concerning how the legal services insurance plan works, you may call Signature LegalCare® at 1-800-848-2012 or visit their web site at www.SignatureLegalCare.com. Scroll down to State of Georgia and enter your 5-digit password (43215).

Signature LegalCare® is underwritten by Heritage Casualty Insurance Company, 200 N. Martingale Rd., Schaumburg, IL 60173, and is offered to State of Georgia employees through a group legal services insurance policy issued to Georgia Merit System, Policy No. 43215. This enrollment booklet is intended to provide a general description of the main features and benefits of this Plan. The exact terms and conditions are set forth in the policy.

Electronic Open Enrollment

New web address! New on-line instructions!

Please read the information below carefully:

Employees can sign on to www.gabenefits.org to select their Flexible Benefits options. Links are provided to access the Flexible Benefits Open Enrollment site and the State Health Benefit Plan's (SHBP) Open Enrollment site. Employees will also be able to access the SHBP Open Enrollment site directly at www.oe2008.ga.gov.

During the Fall Open Enrollment for Plan Year 2008 (coverage period January 1 - December 31, 2008), on-line enrollment is mandatory for all eligible employees who participate in the State of Georgia Flexible Benefits Program, including those hired between September 1 through November 1, 2007 (Note: Special instructions will be provided on-line if the new hire information is not available for the selection of the health benefit option). Employees must select their Flexible Benefits electronically by accessing the web site at www.gabenefits.org. See SPA web site at www.spa.ga.gov for available internet locations if you don't have access at work, home or another location.

The menu design enables you to click on the option, review your available benefit choices and submit your selections on-line. The Summary of Your Selections 2008 page provides a summary of your Open Enrollment selections; the Summary of Your Selections 2007 page lists the options in which you are currently enrolled (excluding health benefit).

Before making your selections, carefully review your 2008 ***You Decide!*** booklet, including "Terms and Conditions" of your enrollment, the "What's New in Plan Year 2008 " brochure and the 2008 State Health Benefit Plan Decision Guide. Entry of your selected options indicates that you agree to the Terms and Conditions and understand this is a binding salary agreement for the duration of the 2008 Plan Year with the exception of the Health Savings Account (HSA). No changes can be made except under limited conditions when you have a qualifying change in status event. For the Health Savings Account (HSA), changes can be made at anytime, on a prospective basis only.

WEB ON-LINE INSTRUCTION
Open Enrollment 2008

System Availability
Wed., October 10 - Thurs., November 8, 2007
4:00 a.m. - midnight

Friday, November 9, 2007
4:00 a.m. - 4:00 p.m.

Web Navigation Help Desk
404-656-3000 / 1-800-264-3941
8:00 a.m. - 5:00 p.m.
(excluding Saturday and Sunday)

GOING ON-LINE

- Go on-line using your regular Internet browser (recommended Internet Explorer 6.0 or higher).
- Type in web-site address: www.gabenefits.org

INITIAL SIGN-ON

ALL employees MUST REGISTER prior to first time login for Plan Year 2008 Open Enrollment.

- Click the Register button.
- Enter the following information:
  - Policy Number (Your social security number without the dashes).
  - Password (Create a password you can remember with a length from 6 to 8 characters. The password is case sensitive so remember how you type it).
  - Repeat password (Re-enter the password you just created).
  - Date of Birth. Click the drop down for your month and day. Type your year of birth (yyyy).
  - Select a security question. Click the drop-down arrow to see the choice of questions.
  - Answer the question (this will allow you to reset your password at a later date should you forget it).
- Click the REGISTER button.

EMPLOYEE BASE INFORMATION PAGE

NEW! NEW! NEW!

Employees will be required to update their marital status online prior to selecting their benefits. The marital status box will appear near the top of the page. It will be defaulted to "U" for UNKNOWN. You must click the drop down box and change the "U" to either "single" or "married" in order to proceed with the enrollment process.

Before making your selections, review the personal data for accuracy. Notify your personnel/payroll office immediately if this information is incorrect, because some premiums are calculated based on this information (i.e. age, benefit salary).

If an error is found, check the web site regularly to determine if updates to your personal data have occurred. You can, however, proceed with viewing the web site even though some information may be incorrect.

NOTE: Please select your benefits, prior to the deadline, as they appear on screen. If the base information is still incorrect on the web site at the end of Open Enrollment and a discrepancy occurs (as determined by the Flexible Benefits Program) in coverage or premium due to incorrect information, a correction can be approved.

You are now ready to review and submit your choices on-line. Click the Continue To Next Page button to view your benefit options.

SELECTING YOUR OPTIONS

Before making your selections, carefully review the Terms and Conditions of your enrollment located in your You Decide! booklet.

Select options in any order you wish. However, there are some exceptions:

- It is necessary to have the Employee Life option before you can select the Spouse Life and/or Child Life option(s).
- It is necessary to have the High Deductible Health Plan before you can select the Health Savings Account (HSA).
- You cannot enroll in both the General Purpose Health Care Spending Account AND the Health Savings Account (HSA).
- It is necessary to have the Employee Specified Critical Illness option before you can select the Spouse Specified Critical Illness option.
- You must complete the medical underwriting section for options requiring medical underwriting (**).

To select an option:

- Click the option in the menu selection on the left side of the page or in the Flexible Benefit Option column in the Summary of Your Selections 2008 box.
- Click the radio button next to the coverage choice except for the Spending Accounts and Health Savings Account options. Please enter **MONTHLY** amount or "00" for the Spending Account and Health Savings Account options.
- Click the SUBMIT YOUR SELECTION button each time you make a benefit selection. Each time you click the SUBMIT YOUR SELECTION button you will be taken back to the Summary of Your Selections 2008 page, except when selecting options that require medical underwriting (**).

(**) See the Special Instructions section for additional entry instructions.

CONFIRMATION PROCESS

- Once you have completed your selections for Flexible Benefits, click the CONFIRM button on the Summary of Your Selections 2008 page.
- Check the box acknowledging you have read and abide by the Terms and Conditions of enrollment.
- If you are not ready to confirm your benefit selections, click the Cancel (I will confirm later) button.
- If you are ready to confirm your benefit selections, click the Please Confirm My Benefit Choices.
- You will be taken back to the Summary of Your Choices 2008 page. A unique confirmation number, date and time will be displayed. Print the confirmation page or write down the confirmation number, date and time for your records.
- If you want to change your selection after confirming on the web site, you may return to the web site as often as you like during the Open Enrollment period to make changes. Each time you complete the final confirm process a new unique confirmation number will be created. The benefits selected as of 4:00 pm Friday, November 9, 2007 will be your final selections.

CONFIRMATION NUMBERS

Your selections are not final until you complete the confirmation process. Print the confirmation page or write down the confirmation number, date and time for your records.

LOG OFF

- Click Log Off when you have completed your visit to the web site. You may sign on again throughout the Open Enrollment period - October 10 - November 9, 2007.

SUBSEQUENT SIGN-ON

- Enter your Policy Number (ssn without dashes).
- Enter your password.
- Click the Login button.

FORGOT YOUR PASSWORD?

- Click I FORGOT MY PASSWORD.
- Answer the security question.

• Create a new password (create a password you can remember with a length from 6 to 8 characters).

(**) SPECIAL INSTRUCTIONS

• Medical Underwriting
  - If you select Employee Life, Spouse Life, Child Life, Long-Term Disability and/or Employee Specified Critical Illness option(s) requiring medical underwriting, you will automatically be taken to a page to complete the form on-line. See instructions on the web site to complete the medical underwriting form(s) online.
  - You must complete the medical underwriting process for Employee Life, Spouse Life, Child Life, Long-Term Disability and/or Employee Specified Critical Illness on-line in order to complete the final confirmation process. You may click the "Finish Later" button to save your entry and return to the web application to finish no later than the last day of Open Enrollment.
  - If you do not wish to complete the medical underwriting form on-line, you will need to change your selection to one that does not require medical underwriting.

OTHER

• You may not select a coverage level in either the Spouse Life and/or Child Life options that exceeds your amount of Employee Life coverage.
• Employee Life After-Tax - If you select over $50,000 of Employee Life coverage, you may choose to pay with after tax dollars by clicking the box in the after tax section on the Employee Life page.
• You may not select the Health Savings Account (HSA) if you have not selected the High Deductible Health option.

Benefit Phone Directory

	Call if you have a question about how the plan works	Call if you have a question about a claim that has been submitted
Flexible Benefits Program		
Employee, Spouse, Child Life Insurance and Accidental Death and Dismemberment		
Life conversion and Portability Information	404-656-2730 1-888-968-0490 or 1-800-660-2519	1-800-660-2519
Dental Insurance		
CIGNA - www.cigna.com	1-800-642-5810	
United Concordia-Regular & PPO www.ucci.com/tuctcc/clients.jsp?id=18	1-866-215-2356	
Vision Coverage www.spectera.com	1-800-638-3120	
Disability Insurance	1-888-641-7186	
Long-Term Care Insurance	1-888-SOG-FLEX or 1-888-764-3539	
Legal Insurance	1-800-848-2012	
Hearing Impaired www.signaturelegalcare.com	1-800-535-2348	
Spending Accounts	1-800-893-0763	
Hearing Impaired www.shps.net	1-800-952-0450	
Specified Illness Insurance	1-866-849-2958	
Portability Information www.spa-specifiedillness.com	1-866-849-2958	
State Health Benefit Plans		
PPO, PPO Choice Option		
Atlanta metropolitan area Contact your personnel/payroll	404-233-4479	
Outside metro area representative. If representative is not available, call claim numbers at right.	1-800-483-6983	
PPO Provider Information	1-800-483-6983	Not applicable
Prescription Drug Information	1-877-650-9342	
Medical Certification Program (MCP)		
Active Employees	1-877-246-4189	
Retirees	1-877-246-4190	
Atlanta metropolitan area		404-233-4479
Outside metro area		1-800-483-6983
Behavioral Health Services (BHS)		
Atlanta metropolitan area	1-800-631-9943	404-233-4479
Outside metro area	1-800-631-9943	1-800-483-6983
NurseCall 24	1-800-524-7130	Not applicable
BlueChoice Healthcare Plan	1-800-464-1367	
Kaiser Permanente	1-800-611-1811	404-261-2825
United Healthcare of Georgia	1-866-527-9599	1-866-527-9599

EMPLOYEE CHECKLIST

❑ Check with personnel/payroll office for deadlines.

❑ Review the enrollment booklet, providing you with valuable information for each option descriptions of required supplemental for medical underwriting requirements (pages 7 & 8, and Terms & Conditions (inside front cover).

❑ During the 2008 Open Enrollment, make your benefit selections on the web site (www.gabenefits.org) from October 10 – November 9.

❑ Check Option Statement and enrollment booklet to confirm if forms are required, such as Medical Underwriting forms.

❑ Review your Confirmation Statement thoroughly and immediately report discrepancies to personnel/payroll office. Follow-up to assure corrections were made.

❑ Compare your December pay stub(s) against options selected. Contact your personnel/payroll office with discrepancies.

Report any incorrect information to your? personnel/payroll office.

Check the following forms that you need to complete and contact personnel/payroll office for forms:

❑ "Flexible Benefits Program Beneficiary Election Form"

❑ Minnesota Life "Evidence of Insurability Form"
- ✓ For Employee Life
- ✓ For Spouse Life
- ✓ For Child Life

❑ AIG "Evidence of Insurability Form"
- ✓ For Specified Illness

❑ The Standard "Evidence of Insurability Form"
- ✓ For Long-Term Disability

❑ Prepaid Dental Option "Dental Selection Form" (call CIGNA at 1-800-642-5810).

Each member must be enrolled with a provider.

❑ HSA Forms

For questions about claims or benefits for the State Health Benefit Plan, see page Benefit Phone Directory for phone numbers.

For general questions about the Flexible Benefits Program, call 404-656-2730 if it's a local Atlanta call, or toll-free at 1-888-968-0490 outside the local area.

If changes in the Program are necessary to comply with the law or IRS regulations, you will be notified.

This booklet summarizes the benefits you can choose through the State of Georgia Flexible Benefits Program. A more detailed explanation of benefit provisions is provided in each benefit plan description. Every attempt has been made to ensure that the information in this booklet is accurate.

The State of Georgia Flexible Benefits Program is governed by legal documentation and insurance contracts. However, in the event there are any conflicts between this booklet and the official plan descriptions and contracts, the terms of the official plan descriptions and contracts will prevail.

The Flexible Benefits Program is governed by the current tax law and is subject to and operated in accordance with the regulations of the Internal Revenue Service (IRS).

PRIVACY AND SECURITY NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities, including state agencies that deal with Protected Health Information (PHI), provide you with this notice. This notice pertains to those programs specifically administered by the State Personnel Administration (SPA) in which SPA may maintain various types of PHI about you. SPA understands that information about you and your family is very personal. As such, SPA is committed to protecting and securing your information.

This notice tells you how SPA uses and discloses information about you and discusses your rights in keeping this information private and secure. Please review this notice carefully.

Overview

What is HIPAA?

HIPAA, the Health Insurance Portability and Accountability Act of 1996, is a federal law regarding the confidentiality and security of Protected Health Information (PHI). It imposes restrictions on how your health information can be used and shared and confirms rights for individuals concerning their own health information.

What is PHI?

PHI, Protected Health Information, is individually identifiable health information that is maintained or transmitted by a covered entity. It is information related to a person's health, provision of care, or payment. Examples of items containing PHI include: a bill for health services, an explanation of benefits statement, receipts for reimbursement from a health flexible spending account or any list showing the amount of benefits paid with a breakdown by social security number. This also includes your employer (state agency, school system, authority, etc.) transmitting information about you to SPA. This information may include your name, address, birth date, social security number, employee identification number and certain health information

How SPA Uses and Discloses Protected Health Information

When services are contracted, SPA may disclose some or all of your information to the company to perform the job SPA has contracted with them to do. SPA requires the company to safeguard your information in accordance with federal and state law.

Privacy and Security Law Requirements

SPA is required by law to:

- Maintain the privacy of your information.
- Protect electronic PHI by implementing reasonable and appropriate physical administrative and technical safeguards.
- Provide this notice of SPA's legal duties and privacy and security practices regarding the information that SPA has about you.
- Abide by the terms of this notice.
- Refrain from using or disclosing any information about you without your written permission, except for the reasons given in this notice. You may revoke your permission at any time, in writing. That revocation will not apply to information that SPA disclosed prior to receiving your written request. If you are unable to give your permission due to an emergency, SPA may release information, if it is in your best interest. SPA must notify you as soon as possible after releasing the information.

Your Health Information Rights

You have the following rights regarding the health information maintained by SPA about you:

- You have the right to see and obtain a copy of your health information. This right would not extend to information needed for a legal action relating to SPA.
- You have the right to ask SPA to change health information that is incorrect or incomplete. SPA may deny your request under certain circumstances or request additional documentation.
- You have the right to request a list of the disclosures that SPA has made of your health information beginning in April 2003.
- You have the right to request a restriction on certain uses or disclosures of your health information. SPA is not required to agree with your request.
- You have the right to request that SPA communicate with you about your health in a way or at a location that will help you keep your information confidential.
- You may request another copy of this notice from SPA, or you may obtain a copy from the SPA web site, www..ga.gov (under "Privacy").

For More Information and To Report a Problem

If you have questions and would like additional information about Protected Health Information (PHI) you may contact the SPA Privacy Officer at 404-656-2730 (Atlanta calling area) or 1-888-968-0490 (outside of Atlanta calling area). You may also visit SPA's web site, www.spa.ga.gov.

SPA does not discriminate on the basis of disability in the admission or access to, or treatment of employment in its programs or activities. If you have a disability and need additional accommodations to participate in any SPA programs, please contact the SPA at the numbers listed. For TDD relay service only: 1-800-255-0056 (text-telephone) or 1-800-255-0135 (voice).

If you believe your privacy or security rights have been violated:

- You may file a complaint by calling the SPA Privacy Unit at 404-656-2730 (Atlanta calling area) or 1-888-968-0490 (outside of Atlanta calling area), or by writing to:

  State Personnel Administration
  Attn: Privacy Officer
  2 MLK Jr. Drive, SE
  Suite 502, West Tower
  Atlanta, GA 30334
- You can file a complaint with the Secretary of Health and Human Services by writing to: Secretary of Health and Human Services, 200 Independence Ave. SW, Washington, DC 20201. For additional information, call 1-877-696-6775.
- You may file a grievance with the United States Office for Civil Rights by calling 1-866-OCR-PRIV (1-866-627-7748) or 1-886-788-4989 TTY.

There will be no retaliation for filing a complaint or grievance.

If SPA changes its privacy or security practices significantly, SPA will post the new notice on its web site at www.spa.ga.gov (Under "Privacy"). This notice, effective April 14, 2003, was amended April 20, 2005.